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Original Articles

A SURVEY OF THYROID ENLARGEMENT AMONG THE SCHOOL CHILDREN OF GRAND RAPIDS*

TORRANCE REED, M. D., and H. T. CLAY, M. D.
GRAND RAPIDS, MICH.

Because of the recent work in the prevention of goiter by Marine and Kimball, there has been an increased interest in this phase of preventive medicine, especially among those interested in public health work. The striking results obtained by Kimball (1) in the prevention of simple goiter among the school children of Ohio, are well known. Previous to the institution of this preventive work, a survey among the girls in the schools of Akron, Ohio, showed a goiter incidence of 56 per cent. In the Zurich, Switzerland, district, Klinger (2) found an incidence of 85 to 95 per cent.

Michigan lies in a well known goiter district. In view of the suspected prevalence of goiter, it was decided by the health officer of Grand Rapids, Dr. C. C. Slemons, that a survey should be made of the school children for the purpose of determining the incidence of goiter in Grand Rapids. This survey included all the school children of Grand Rapids from the kindergarten through the high schools, including private, parochial, and public schools. To the best of our knowledge no survey has been previously made so complete as this, that included both boys and girls. Kimball's survey was confined to the girls.

Dr. Kimball was interested in this matter, and came to Grand Rapids, where he delivered several public lectures on the subject of goiter and its prevention. Dr. Kimball and the examiners jointly examined a large number of girls in one of the high schools in order that a standard for comparison might be established and the work made comparable with that done in Ohio.

With this preliminary work the survey was begun. The two examiners jointly examined one school in order that their classification should be as nearly alike as possible. Following this the schools were divided so that each examined approximately one-half of the total number examined.

A classification was adopted to facilitate the work. This consisted in calling the normal thyroid No. 1; the slightly enlarged thyroid, No. 2; those greatly enlarged, No. 3; and those thought to be adenomas were called No. 5.

Each child was given a small card upon which he wrote his name, age, grade and sex. They then formed a line, and passed by the physician, who repeated the number of the classification, which he judged it to be, to the nurse, who wrote this number upon the card. In this way it was possible to examine a large number of children without an appreciable interruption of the school routine.

The thyroid area was inspected with the child facing a good light, and then palpated. Those who showed no enlargement of the gland on inspection or palpation and through whose thyroid one could palpate the tracheal rings, were called normal. The others were classified according to their size as we had agreed; viz., No. 2, 3, and 5 in proportion to their enlargement and type.

An additional test was frequently applied; that is, palpation of the gland while in the act of swallowing. Many slight enlargements were demonstrable in this way. Many cases, in which there might be doubt of the presence of a slight enlargement, were classified as normal rather than slightly enlarged, believing that it was more desirable in a survey of this sort to incline to the normal in cases of doubt.

There were 26,215 pupils examined. Of this number 30 per cent had enlargement of the thyroid gland. Of this 30 per cent, 32 per cent were boys, while 67 per cent were girls. It was therefore shown that enlargement of the thyroid gland is approximately twice as prevalent among girls as boys. Numerically there

*Based on examination of 26,215 school pupils of both sexes.

(1) The Prevention of Simple Goiter in Man—David Marine and O. P. Kimball—Jour. A. M. A. 77-14—Oct. 1, 1921.

(2) Prophylaxis of Endemic Goiter—R. Klinger—Schweizerische Medizinische Wochenschrift, Basel—51-1—Jan. 6, 1921.

were 12,631 boys examined and 13,584 girls. Of these, 7,839 children had enlargement of the thyroid gland; 2,603 were boys and 5,236 were girls. Among the high schools the percentages of enlargement of the thyroid were found to be uniformly high as will be seen by the following figures: Union High school, 52 per cent; Central High school, 48 per cent; South High school, 44 per cent; Christian High school, 60 per cent; Catholic High school, 39 per cent. These figures include both boys and girls.

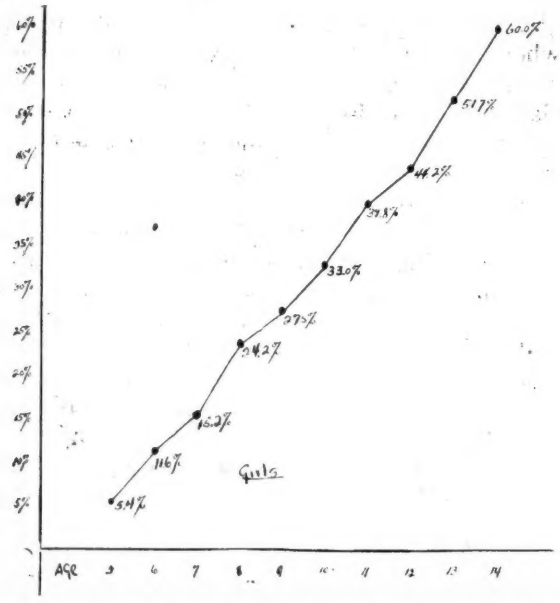
The following table shows the incidence of enlargement of the thyroid gland among boys and girls under and over 10 years of age respectively.

	Under Ten	Over Ten	Total Enlargem'ts	Total Examined
Boys ...	623	1938	2561	12,631
Girls ...	1073	4205	5278	13,584

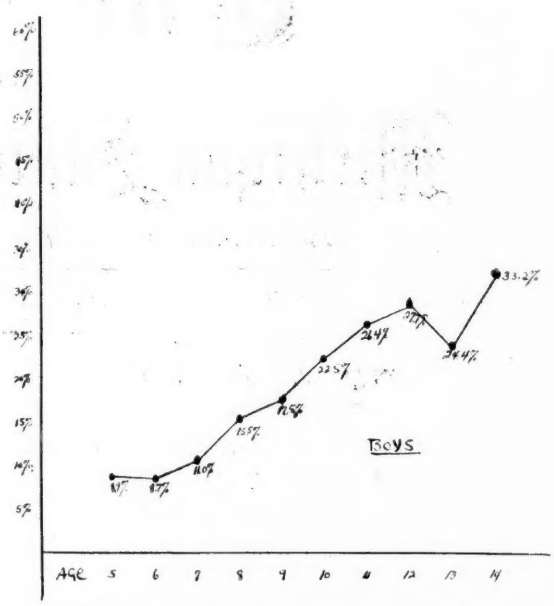
By referring to the table, it will be seen that there are in this total approximately twice as many enlargements of the thyroid among girls as boys; above 10 years the ratio is about two and one-half times as many; while under 10, there are less than twice as many among girls as compared with boys. The changes occasioned at puberty among girls are perhaps accountable in part for this greater incidence.

No exopthalmic goiters were observed during the survey.

In order to show the incidence of enlargement of the tyroid at the various ages among grammar school children, the following graphs were made.



Age Incidence of Enlargement of the Thyroid Gland Among Grammar School Children of Grand Rapids



Age Incidence of Enlargement of the Thyroid Gland Among Grammar School Children of Grand Rapids

The curve of the graph show a gradual, steady increase in the incidence of enlargement of the thyroid from the age of 5 to 14, the greatest incidence occurring at 14. The curves show the same gradual increase among both boys and girls.

In view of this prevalence of enlargement of the thyroid, the health department of the city of Grand Rapids, with the consent and approval of the Kent County Medical Society, has undertaken to prevent goiter among the school children. This consists in the giving of 10 milligrams of iodine weekly for 40 weeks throughout the school year. No child has been given treatment without the written consent of its parents. The iodine is given by the school nurse in the form of a chocolate confection made by one of the large pharmaceutical houses.

SUMMARY

1. The general prevalence of enlargement of the thyroid gland among the school children of Grand Rapids was not appreciated until this survey was completed. Thirty per cent of the children examined were found to have enlargement of the thyroid gland.

2. Prevalence of thyroid enlargement among boys is much greater than is generally supposed .

3. There is a gradual increase in the number of enlargements from 5 to 14 years, the highest number being found at 14 years.

4. Enlargement of the thyroid gland is twice as common among girls as boys in Grand Rapids.

5. The incidence of thyroid enlargement among the girls as compared with the boys is greater over 10 years of age than it is below that age.

CONCLUSION

The health department of Grand Rapids feels that goiter prevention is a public health measure; that being of interest to the general public health, it can therefore best be taken care of by public health officials through the organization of public school nurses and physicians. The Kent County Medical Society shares and approves this view. Consequently, the school children of Grand Rapids are at present being given tablets containing iodine with these preventive measures in view.

There has been a general widespread interest in this campaign to prevent goiter. Parents have shown a greater interest in the attempt to prevent enlargement of the thyroid gland than in any of numerous other health activities.

We have found that enlargement of the thyroid is twice as prevalent among girls as compared with boys, but it should be stated that the moderate and the marked enlargements are probably in about the ratio of six or eight to one as compared with boys. The slight enlargements which were so common among the boys as to bring their total incidence to approximately 50 per cent that of the girls, are the enlargements generally overlooked. We believe that this failure to discover the slight thyroid enlargement among the boys is the reason for the prevailing erroneous opinion that simple goiter is about eight times as prevalent among females as among males.

VENEREAL PROPHYLAXIS—A RESUME

EUGENE S. BROWNING, A. M., M. D.
GRAND RAPIDS, MICH.

It is unnecessary to say that venereal diseases should not be treated in the light vein which was the custom years ago. Physicians have erred in treating these maladies as a joke. Patients nowadays realize to some degree the seriousness of their condition, and will soon tire of the medical adviser who treats their disease as of little importance.

As to the prevalence of venereal diseases, we have no adequate basis of comparison. The state's intervention has brought to our attention a great number of the floating population, who previously did not frequent the physician's office, but treated themselves. This is especially true of many prostitutes who acted as the source of distribution. However, the education of the population during the recent war period on venereal disease has enlightened the public to the extent that more people come to the physician for examination who would otherwise have used patent preparations.

The Question of Fitness for Marriage—When a patient propounds to the physician the question of his fitness for marriage, the medical man should realize the importance of the answer to this question, that as a result of his judgment, the man and wife may enjoy a life of happiness or may be doomed to years of misery and a series of operations, or even death may ensue. We should therefore exhaust every laboratory method, including the Wassermann test, spinal puncture, examination of urine, urethroscopy, smears, and microscopic examination of fluid expressed from the prostate. We frequently see married couples whose misery could have been avoided by the proper answer to this all-important question, many times naming the doctor who treated their query lightly.

Patients with venereal diseases often come to our offices, whose quest it is to decide the guilty party or the source of infection, rather than the best means of curing it. The physician should not attempt to be judge or jury, but should save himself a great deal of unnecessary trouble by refusing to take sides in this argument.

Cleanliness—Every patient suffering from gonorrhea should be impressed with the great necessity of keeping his hands and person absolutely clean; after every exposure to wash the hands in running water, and not to use soap which he afterward might use for his face and hands, or that anyone else might use, and to wipe his hands on paper toweling which is afterward thrown away. The proper use of the gonorrheal apron and the suspensory should be recommended. Patients frequently say this advice had never been previously given, and that the physician had no facilities for washing the hands in the office they had previously visited. This advice may also be taken by physicians, many of whom have lost eyesight by gonorrheal infections. This condition is far from uncommon. Many patients, before washing their hands, count out money which they give to the physician, the money becoming contaminated. This is tainted money with a vengeance. The female patient should be advised to sleep alone. If another woman, or especially a child or infant, sleeps in the same bed, the woman or child may become infected, just how we do not know. If one infant suffering from gonorrhea is received into a children's home, the infection becomes general.

Circumcision should be performed far more often than is the custom. This is a prophylactic measure, both for uncleanliness and disease.

The double standard of morality has long existed and the youth of today should have their minds disabused of this mirage. The fallacy of the necessity of sex indulgence and the danger thereof should be impressed upon

the youth. Public education and lectures by the government in this direction, and free literature by the state are all helping the cause of venereal prophylaxis. Dr. Carrier, (deceased, and formerly professor in the Detroit College of Medicine), gave the first public lecture in America on venereal prophylaxis in Detroit, Mich. Since then public lectures for both men and women have become frequent.

Don't discourage patients, yet it is not best to make rash promises of speedy cures, but rather hold out the value of completely eradicating the disease. Prophylactic treatment during the first 12 or 24 hours is of great value, yet it is not best to hold out this thread as a safeguard to indiscriminate exposure. After the acute symptoms, frequency, ardor, etc., have developed, it is then dangerous to attempt to abort the condition. As a general rule, it is not wise to attempt abortive treatment in the initial case of gonorrhea, as we know nothing of the patient's resistance or the reaction to the injections or irrigation. There is constantly before us the danger of over treating cases which are finally cured by cessation of medication. An important differentiation is whether the case in question is chronic or a new, superimposed upon the old. Don't use sounds or any instrumentation upon a patient who comes with a history of exposure during the preceding seven days. It is best not to accept his word. Be a watchman for the first week, aided by examination of urine and internal treatment. Be careful of irrigations, lest you do more harm than good by too great pressure or too strong solutions. The complement fixation test has about been discarded; it is of use in old cases of rheumatism, but otherwise has not lived up to expectations.

Gonorrhea in women as well as men, is of importance from an economic standpoint; fellow workers refuse to be employed with those who are infected, if it is known. Of those employed around food emporiums, the law demands frequent examinations. It is our duty to report every case, regardless of the lineage or status of the patient. As gentleness is the watchword in treating male patients, it is true to an even greater extent in the treatment of women. Any applications to the cervix must be made with caution in order that you do not extend the condition to the uterus and tubes. Should this occur, an operation may be the price to the patient.

Non-Specific Urethritis—This is a much abused subject and the basis of innumerable jokes, but truth is stranger than fiction. This condition really exists, and to a far greater extent than most physicians realize. Doubtless many cases have been reported when the individuals were honest in their statements and innocent of harboring gonococci. A microscopic examination or culture is the final arbiter. Examination of the prostrate, if it be a chronic case, and examination of the fluid expressed may clear up the case. Read any good author on urology, whether it be the Frenchman, Luys, or an American authority, and you will be surprised at the number of pages devoted to non-specific urethritis. I know, personally, of families broken up and divorced upon the hasty word of a physician, when gonorrhea did not really exist. So be careful, and have smears made and examined locally or sent to the state board of health and examined free, which leaves no excuse. As Chetwood says:

"Simple or Non-Specific Urethritis—In this form, the patient gives himself the disease more often than his partner gives it to him. The evidence of irritation appears almost simultaneously with the cause, or on the second day following; sometimes it is delayed longer. A damaged mucous membrane with any one of a number of exciting causes is sufficient to kindle the slumbering congestion into active discharge and inflammation, with the aid of those microorganisms which constantly ihabit the urethra, and under normal conditions remain there as harmless saprophytes.

"In these cases, the discharge may originate at a certain distance within the urethra from the very start, or it may commence at the meatus. The patient has intercourse, perhaps, with a woman who has no gonorrhea, who has at most a purulent leucorrhea. In 24 hours to 48, he presents himself to the physician for inspection, stating that he has an attack of gonorrhea."

This classification is made by Luys of France:

1. Inflammation of the urethra due to common micro-organisms.
2. Inflammation of the urethra said to be (aseptic).
3. Inflammation of the urethra due to chemicals.
4. Inflammation of the urethra due to a special diathesis.
5. Inflammation of the urethra of toxic origin.
6. Inflammation of the urethra of traumatic origin.

The following bacteria have been cultivated from the normal urethra.

Aerobic:

Staphylococcus albus.
Staphylococcus aureus.
Staphylococcus citreus.
Bacillus pseudodiphtheriae.
Micrococcus subflavus of Bumm.
Micrococcus lacteus farifomis of Bumm.
Micrococcus citreus conglomeratus of Bumm.
Streptococcus urinarius.
Streptococcus giganticus urethrae of Lustgarten.
Pseudogonococcus of Steinschneider.

Anaerobic:

Various strains of staphylococci.
Bacillus ramosus.
Bacillus refrigens.

Of the pathogenic organisms the colon bacillus is productive of the greatest number of infections. Its source is either venereal or its presence is due to direct extension from the rectum. Next in frequency are the staphylococcus, then micrococcus catarrhalis, and last, the streptococcus. Isolated cases of urethritis are recorded from pure cultures of bacillus lactis aerogenes, pneumococcus and bacillus pyocyaneus, and the pseudodiphtheria bacillus.

It is extremely dangerous to begin treatment of any venereal condition without examining the penis, yet this seems to be a common procedure. How do we know whether phimosis, paraphimosis, chancre, chancroid, hernia, bubo, pediculi, or any number of conditions exist, without completely exposing the patient.

The Woman's Side—Women's magazines are informing their readers on these modern subjects. Patients are surprising us daily by their well advised questions. The time is past when you may say it is all right for young men to sow their wild oats and expect to marry clean young women, and expect them to help reap the harvest of sterility, miscarriage, pelvic operations, feeble-mindedness, locomotor ataxia, paresis (ophthalmia neonatorium) and syphilitic children.

The Wassermann Test—This test is one of science's most beautiful and helpful gifts to suffering humanity, yet numerous physicians are writing articles in magazines, declaring this aid to be a failure and even a menace. By all means give your suspicious cases the benefit of the Wassermann. If you do not, your patients are going to some man who will. This test was perfected in 1905.

At one time in Philadelphia, 17 physicians from various parts of the state of Pennsylvania were being treated for syphilis, the initial source being on the fingers caused by making pelvic examinations without gloves. Yet this gross error continues. Examinations are made, women confined, and rubber gloves are not worn. This is, of course, inexcusable. The simplest appearing ulcer or chancroid on the penis or elsewhere may contain the Spirocheta Pallida. The dark field will expose these invaders several weeks before they invade the blood stream. At this time, treatment may be given and the patient saved from serious disaster. By all means take advantage of the security which this modern aid offers your patient. Laws should compel restaurants and soda fountains to boil glasses and dishes, as the Spirocheta Pallida may live for eight hours on such utensils, if sufficient moisture is present.

Authorities agree that syphilis is the most prevalent disease today, perhaps with the exception of measles. No matter, therefore, what your department of medicine may be, you should always be on the lookout for some of the numerous signs and manifestations of syphilis in your obscure and obstinate cases.

To view these cases intelligently, the physician must forget the family's respectability and position in society, etc., and take advantage of all laboratory examinations, remembering that 8 per cent of the people with syphilis have been inoculated innocently. General hospitals where routine Wassermann's are made, have found as high as 18 per cent of their patients with a positive Wassermann who did not know they were infected.

According to the most accurate statistics as given by the American Social Hygiene Association, syphilis is the greatest killing disease in the world today, the death rate being for syphilis, 222 per hundred thousand, tuberculosis, 141.6, and pnenmonia, 88.8.

Remember, syphilis is a preventable disease. The proportions of deaths under other classifications, that should be ascribed to syphilis, is as follows:

Disease	Per Cent
Locomotor ataxia	100
General paralysis	100
Congenital debility, icterus and sclerema	100
Organic disease of the heart	50
Angina pectoris	50
Diseases of the arteries, atheroma, aneurism	40
Cerebral hemmorrhage, apoplexy	40
Softening of the brain	40
Bright's disease	20
Epilepsy	10
Encephalitis	10
Meningitis (total)	10

Ninety-six per cent of the prostitutes in the red light districts are venereally diseased. This report covers 320 prostitutes on the Barbary coast, San Francisco, Cal., who were visited and examined. The examination was for syphilis only, and showed 97 per cent diseased. Of 289 prostitutes of the Baltimore red light district, 96 per cent were found to be infected. The results of a raid on the red light district in Pottsville, Pa., showed that 81 per cent of 31 women were infected. The examination of 224 prostitutes from the Detroit red light district, for both gonorrhea and syphilis, showed 94 per cent to be infected.

This demonstrates clearly the terrible chances the young man takes who goes forth for adventure. The girl who starts out on the road, wrongly named the easiest way, doesn't travel very far before she becomes diseased. Many have confided to me that it was the price of the first step.

Seventy-two per cent of the prostitutes outside of the red light district have at least one venereal disease. Of 6,000 women examined in eight states, 70.1 per cent had syphilis or gonorrhea, or both. Thirty-three per cent of

all prostitutes are feeble-minded. This should be of importance to society and the tax payer, especially.

Ninety per cent of all sexually acquired syphilitic infections in men are derived from prostitutes, either professional or amateur. Fifty per cent of all syphilitic women are infected innocently. Seventy per cent of women who came to New York hospital for venereal treatment, were respectable married women infected by their husbands. Eighty-five per cent of married women who have syphilis, have contracted it from their husbands. Ten per cent or more in England have syphilis. Twelve per cent in Berlin have syphilis. Thirteen to fifteen per cent of the adult males in Paris are infected with syphilis. Venereal disease is so prevalent in Russia that in some of the small towns practically 100 per cent of the population is infected.

In the Michigan State Hospitals for the Insane, it was found that syphilis was a direct cause in 17.5 per cent of all male admissions, and 6.65 per cent of all female admissions.

One of the crying needs in Michigan, as in every state, for protection of innocents to prevent this awful slaughter, immeasurable suffering and heritage of distortion, is an adequate marriage law which demands of the contracting parties a complete examination for venereal diseases, to include the Wassermann for both male and female. The proper place for such a law to originate is the Medical Society. The laity has a right to expect the medical men to protect them. We have thus far permitted too many other societies and cults to abrogate our proper sphere. The City of Grand Rapids, Mich., has just adopted an ordinance compelling drug stores, restaurants and soft drink parlors to properly boil or wash their glasses, plates, spoons and utensils, to protect people from innocently acquiring syphilis. This ordinance had its inception in the action of the public health education committee of the Kent County Medical Society. Needless to say not all of the stores obey this rule, and neither will they do so until the people demand proper cleanliness.

Niesser's discovery of the gonococcus as the specific cause of gonorrhea in 1879, the Wassermann test and spinal fluid test, discovery of Spirocheta Pallida, April 5, 1905, by Schaudin and Hoffman, the dark field for the initial sore, the same being utilized for identifying Spirocheta Pallida in the tissues and organs after death, perfection of Neo Salvarsan and Arsphenamines, public education, legislation and clinics are the important milestones in the fight against venereal diseases, that is, gonorrhea and syphilis. This is a fight to the finish in which every physician must do his part to educate the public, if civilization as we know it, is to remain intact.

One of the most recent and far reaching forms of prophylaxis is represented by six clinics in New York city, for the treatment of congenital syphilis. This work was begun by Dr. Fordyce and associates. Its immense value was immediately recognized. For children, Neo Arsphenamine neutral in re-action and especially prepared for intramuscular injection, is used, followed by mercurial injections. Syphilis is the most frequent cause of still births, from 20 to 50 per cent. Maternity hospitals in New York are now investigating the history of their prospective patients to determine the presence of syphilitic infection. Blood examination is required. It has been found that the pregnant woman's blood may give positive re-action with Cholesterinized Antigen in some cases in the absence of syphilis. Syphilitic mothers treated give birth to healthy children. The children are kept under supervision, and frequent examinations are made at the clinics.

In most states where attempts were made recently to adopt laws for compulsory examinations as a requisite to obtain a marriage license, the attempts failed. When we physicians realize our duties to the public and perform the same by educating the people and having every Medical Society in the state demand such a law of the legislature and go to the capitol and fight for the law, then failure will not be recorded. As medical men, we know well the venereal menace, and realize the importance of a clean bill of health for those contemplating matrimony. I have frequently had patients consult me about venereal disease in the morning, and notice their marriage license in the evening paper.

Overy 40,000,000 American people have deserted physicians for the various cults, religions and health associations with all kinds of pedigrees. We allow the laity to conduct public health campaigns of all kinds, with paid secretaries and workers, and physicians are not concerned or consulted. This same thing applies to the venereal disease problem.

THE FUTURE OF MEDICINE*

H. B. BRITTON, M. D.
ANN ARBOR, MICH.

It was in the most critical formative period of our national history that Patrick Henry said: "I have but one lamp by which my feet are guided, and that is the lamp of experience. I know no way of judging the future but by the past"—and in venturing upon the somewhat delicate occupation of prophecy, it may be

*Read before the Washtenaw County Medical Society at its May meeting.

well for us to glance at the past for comparison with the present before attempting to trace the probable onward trend of medicine.

Two impressions spring into view with the first general consideration of maladies among the most ancient of our known ancestors. One is their importance among the events of primitive lives; the other is the impossibility of any adequate conception of their causes. As might be expected, from these two facts arose the inevitable conclusion that maladies were supernatural manifestations, and their consideration fell consequently into the province of the primitive priesthood. As all religions, primitive and otherwise, are based upon beliefs or faith rather than on demonstrable facts, empiricism was a characteristic of the treatment of disease from the beginning of medical practice.

The truth of this is very evident from the remarkable prescriptions written in early Egyptian papyri and cuneiform inscriptions of Babylon and no less so in the later writings of Esculapius and Hippocrates. It would appear that it was almost an offense against the deities to apply gross material reasoning to the mysterious and awful visitations so obviously inflicted by the easily offended gods. However, in these very early times when the cause of a malady was evident and amenable to mechanical treatment the ancients showed surprising boldness and skill. Abscesses were opened with bronze lancets before Abraham's time; broken bones were set correctly, even cataracts were couched, if we interpret records correctly. And most remarkable of all, neolithic man thousands of years before the period of the first written documents, performed trephining as neatly and efficiently as can be done today. One prehistoric skull shows five circular openings from three to five centimeters in diameter, made at successive periods years apart. The patient had survived them all. One is in doubt whether to admire more the courage of the surgeon or the confidence of the patient when this operation was approached with but a handful of flint chips for complete equipment.

The first record that we have of a bold rebellion against the heavy shackles of fear and tradition is that of the giant intellect of Aristotle, of whom William Osler says, "No man has ever swayed such an intellectual empire in logic, metaphysics, rhetoric, psychology, ethics, poetry, politics and natural history—in all a creator, and in all still a master. The history of the human mind offers no parallel to his career. The creator of the sciences of comparative anatomy, systematic zoology, embryology, teratology, botany and physiology."

From the time of Aristotle the character of medicine changed, but it was by no means a steady progress, for thinking is a rare function of the human mind. Having made this statement so frankly, I believe I had better entrench my position in anticipation of the counter attacks invited. I would define thinking as the process of drawing just conclusions from observed facts and assume cheerfully that I make no pretensions whatever of doing any more of it than any other man of my inches. To resume. From the time of Aristotle some 800 years forward until, and through the dark ages, there were here and there, in an ocean of superstition and ignorance, men who thought while they studied the basic medical sciences. (How clearly Aristotle had perceived is shown in his statement, "Health and disease also claim the attention of the scientist and not merely the physician, in so far as an account of their causes is concerned").

The great names are familiar to us all. Prayagoras and Herophilus of the Alexandrian school; Galen of Ionia, Ancema of Arabia, and with the rise of the universities in the thirteenth century, Paracelsus, Roger Bacon, Vesalius, Harvey. Each man added to knowledge because he drew just conclusions from observed facts.

* * * *

The enormous expansion of the sciences in the nineteenth century has given so vast a wealth of facts upon which to base conclusions that an unprejudiced observer (one free from the peculiarities of the human mind) might say there was little possibility of diverse opinions. But let me mention for your consideration the anti-vaccinationist, the Christian Scientist, the enthusiastic chiropractor, and our brother, the devotee of the thirtieth dilution. We, the elect, who, of course, hold the only true light should not be too acid in our attitude toward those who are honest, though erring. We may be both unwise and unkind. The late medical historian, Dr. Payne, remarked: "The basis of medicine is sympathy and a desire to help others and whatever is done with this in mind must be called medicine. Dr. Camp, in his brilliant paper, read recently before this Society, reproved our hidebound complacency in scorning the valuable aid of suggestion which the Christian Scientists have used so efficiently to their satisfaction and our discomfiture. Not all of our patients have the sturdy character of the fine old man who called me after a series of treatments from an osteopath, and paid me the compliment of saying he preferred to die in the hands of a gentleman rather than survive in those of a fool. There have been cults and fads throughout history. The human mind has changed little in the last 6,000 years, nor is it likely to change more in coming centuries. We are always prone to break away from the stony

beaten path of the hard won cumulative knowledge of the race to follow the fascinating ignus fatius of any extravagant idea plausibly flashed in our dazzled eyes. This is human nature, and by no means applies to medicine alone. Finance and politics are amply provided with what Roosevelt called, the "lunatic fringe." But, as Dr. Camp has pointed out, it will be well for us to examine with an unprejudiced eye any fad that has contented many people, and to make honest use of its armamenta (armamentarium).

It is to give and take on both sides, for the Christian Scientist has concluded to die since the passing of the founder of that faith, and of late his call upon us to replace them. In the future he may be able to recognize the difference between a suppurating wound and a clean one; and then perceive a pathogenic micro-organism as an existing entity; and finally confine his practice to those cases of psychic disturbance in which he is notably successful. All one idea cults begin as a very narrow and acute conception. One might represent them graphically by a line rising very rapidly from the abcissa and then descending as acutely. As time goes on, facts, which are stubborn things, broaden the base and if the area of the graph, which represents the truth of the idea, remains the same—the ordinate of the apex comes down—the curve flattens out. The broader grows the base of facts, the less does the top of the hill rise above the general level of truth and in the course of time it sinks close to the line of our common concepts. May I apply this analysis to homeopathy, which we recall began in a very strictly limited application of the idea of similia sumilibus currantur; but today we are unsurprsed when our brother prescribes five grains of acetyl sal, or a quarter of morphine. And, on our side, we seldom give with the felicity of our grandfathers, a teaspoonful of calomel. I, myself, have sometimes conversed with the professed and self-acknowledged homeopath and found him like Kipling's soldier:

> "We ain't no thin red heros
> We ain't no blackguards too,
> But single men in barracks
> Most remarkable like you."

I am informed that the Still College of Osteopathy offers a four years' course to the prospective graduate, and that the found practices, or did practice, surgery; and my amour propre was given a severe jolt a week or so ago when a practical nurse informed me that an osteopath told her he was prepared to care for obstetric cases and desired her to refer such to him. Can it be possible to destroy this monster of iniquity by boring from within? Could it be conceivable to put a real bacterologist, a real anatomist, and a real physiologist into the chairs of an osteopathic college and infect the unsuspecting students with actual facts, with the hope that he might draw the conclusions that smallpox was not necessarily the result of an abberation of a lumbar vertebra to which the X-Ray was blind? And, on our side, can we burden the already appalling curriculum of our schools with a chair of massage and train an adequate corps of masseurs to carry out our prescriptions for the benefit of those helped by this form of treatment, and add one more specialty to the fecund brood that multiplies faster than the dragon's teeth that Jason sowed?

The problem of specialization is becoming formidable. We have already a vast amount of what might be termed specialized knowledge. I would apply that term to the refinements of technique and information that are beyond the scope of the general practitioner. This latter gentleman is being spread pretty thin in an endeavor to cover adequately the ever widening empire of medicine and his elastic limit being appreciably less than infinity is likely to cause a rupture in some part that will result disastrously. The obvious answer to this is that the general practitioner should limit himself to the area which he can cover—but when he does that, becomes a specialist and we are just where we started unless we agree that the general practitioner shall join the dodo in extinction. A possible solution of this imposse may lie in the development of group practice which has many features to commend it, but like every other good thing in this world, lacks absolute perfection; one defect being the frequently mentioned loss of intimate relation with one's own physician who is "guide, philosopher and friend, whose personality more than compensates for his castor oil, and whose presence may cure more than his quinine." Another obstacle is the increased cost to the patient of multiple consultations and diagnoses. Nevertheless, group practice, formal or informal, appears to me inevitable whenever "two or three are gathered together," and if we are to do just to our patients and ourselves. It is, of course, impossible in the sparsely populated districts where the lone physician will continue as in the past, to cover many miles between midnight and midnight, diagnosing and treating everything from abscess on the first page, to zymotic disease on the last, as best he may. He occupies the first line trench and cannot be as precise and scientific in his fight as the heavy artillery at headquarters in the rear.

The little community hospitals springing up in the small towns will be a large factor in furthering group practice. The hospital is the natural center and meeting place of physicians where the tendency to invite consultations is almost automatic. This is a highly salutary tendency and a practice which should be encour-

aged. The tremendous advantages of a hospital can be best appreciated by one like myself, who has spent the better part of a professional lifetime without it. Some of the laity, in fact, are regarding the hospital as a sort of impersonal general practitioner, and present themselves there for treatment and advice without the formality of consulting previously any physician. They do even better. I was told that a mother called the hospital by telephone and asked that a nurse be sent to see her sick child. The superintendent suggested the advisability of calling a physician and received the naive reply that she had one, but would be better satisfied if a nurse from the hospital take the case. The institution which has established such confidence in a community surely justifies its existence. The transition to group practice by the aid of the hospital is easy when the physicians will specialize according to their number, and the needs of the community cooperating as a unit to the best advantage of all. I should be very glad to hear from some of those who have had actual experience in group practice.

Specialization is not a modern development. Herodotus, referring to the Egyptians, said that the country was full of physicians—"one treats only the diseases of the eye, another those of the head, the teeth, the abdomen, or the internal organs." It would be interesting to compare the curriculum that was laid out for the student in those days with that of the present, and estimate that of the future. A few months ago, the professor of mathematics at Perdue told me that at mathematical societies even the titles contained expressions he had never heard of. We have not gone that far in medicine as yet, but I confess to having frequent and sometimes futile consultations with the dictionary when reading some of our medical papers. I think we may anticipate the time when it will be imperative for a student entering upon a medical education to have a definite specialty in view because he can no longer, like Faust, "have all knowledge for his province." We have mechanical, electrical, chemical, civil and sanitary engineers who make no pretension to even a bowing acquaintance with one another's fields of work. Are we to come to the point where we must cast overboard the fundamental axiom that no man may specialize until he has mastered general medicine?

What sort of warped treatment will be advised by the gastrologist of the future whose cimmerian darkness lies north of the diaphragm? Perhaps by that time we will have determined long before his graduation, just how and when he will graduate. In my day, all children at 6 were fit to enter the first grade, and all youths at 14 were prepared to enter the high school. It is true that here and there hitches occurred in the pleasant simplicity of this program of the nineteenth century, and, stuck fast in the lower grades were found adolescent bumpkins, from whose thick cranium the multiplication table bounced harmlessly like hail from the shingles, much to the perplexity and confusion of the educators. Since that day it has dawned upon us that mental capacity cannot be accurately gauged by age alone.

Psychologists, teachers and physicians have been occupied with contriving scales, more or less accurate, for testing mental capacity and applying them with surprising and disconcerting results. This, I believe, is breaking ground in a highly important direction. A vast amount of energy and time have been wasted and a flood of woes inflicted upon children in the effort to sift coarse and fine through the same educational mesh. Here is a new specialty. Let us imagine a clinic directed by a medical graduate who is a psychologist, with a stac, part of whom are trained in physical diagnosis, and part of whom are trained in the application of a comprehensive and accurate system of mental tests. The child, say at 6, is examined in this clinic and the course of study—and physical treatment, if necessary—prescribed for the year. At 7, re-examination and consideration of the progress of the past year may be the basis of the prescription for the following year, and so on, at such intervals as experience dictates. In the more densely populated areas—cities, groups could be formed of those holding similar prescriptions with some expectation of uniform results in education which should be commensurate with the effort expended upon them.

This should get the most out of the material available with the least ecort. But, will such a system be practical and will it be worth the trouble? Another advantage might be derived from such a system. Dr. Jacoby, psychiatrist of the Detroit recorder's court, spoke a few weeks ago in this room. He parallels the care of the criminal with that of the insane, considering both as manifesting "abberations of behavior." Proper examination may possibly indicate criminal tendencies in those who have never committed crime and give opportunity for prophylaxis. It is certain that the present legal treatment is woefully inadequate in the care of the "abberation of conduct" after it is full blown. Dr. Jacoby's suggestions are startling at times, but no more so than the facts upon which he bases them. I believe he is a pioneer in a field of almost unbounded possibilities, and that a great task of the psychiatrists will be to remodel the medieval methods of our present-day handling of crime and criminals. Our own profession may be conservative, but in comparison with legal procedure, cramped

as it is by paralyzing precedent, we are progress itself. There are valid arguments for supporting the view that criminal tendencies, as well as insanity, are due to physical causes. If crime is analogous to insanity, it is certainly the privilege and the duty of the medical profession to study and handle it. Can we look forward to judicial authority being invested solely in the medico-legal psychiatrist, educated exclusively for his peculiar career?

We are looking far into the future. One more step before I close. We agree that in general, prophylaxis is preferable to cure. Can we in trust to our new judicial authority the task of abolishing criminal tendencies and degeneracy; eliminating the criminal, the degenerate, and the feeble-minded entirely from the body politic by definitely preventing reproducts in all these classes?

In the opinion of this group of medical men, what would be the race in 500 years if the whole lower tenth—the tenth lowest in physical and mental capacity in each general, were eliminated from reproductions?

THE RELATION OF EDENTULOUS JAWS TO SYSTEMIC DISEASE

CHARLES A. TEIFER, M. D., and
J. F. WOOD, D. D. S.
MUSKEGON, MICH.

ETIOLOGY

Improper removal of abscessed teeth may be considered the etiological factor in the majority of cases of infected jawbone. Failure to remove the abscessed sacs and surrounding infected bony and soft tissues at the time of tooth removal is also a factor. Abscessed teeth which are extracted by the method which is used by the majority of dental practitioners, viz.: "pulling" of teeth and little or no effort made to remove the necrotic bone or abscess sacs; latent jaw infection is almost inevitable. The gums in some cases are slow to heal over, but eventually the necrotic jaw is covered by healthy pink overlying tissue. The patient has had the teeth extracted with the hope that it may benefit his bodily complaint and in some cases the symptoms disappear for a time and sometimes disappear entirely, only to manifest themselves in another part of the body. This is due, probably, to the fact that the infection is stirred up and it automatically produces an autogenous vaccine. The patient may have a definite manifestation due to focal infection, but when the teeth have been extracted we generally feel that we should not consider the toothless areas as factors in his complaint. The failure to remove portions of roots at the time of extraction is also a frequent cause of systematic manifestations. Failure to recognize and properly treat maxillary sinus infection which may be a primary or a contributing factor in the production of the jaw necrosis should not be overlooked.

PYORRHEA

The same may be said concerning teeth where pyorrhea is present and in the moderately advanced stages and where the teeth have been just "pulled" and the adjacent abscessed bone and soft tissues have not been removed and properly drained. The X-ray is a valuable aid in suggesting to us the extent of the bone pathology around the abscessed teeth and the teeth affected with pyorrhea, but too much reliance cannot be placed on the same. The patient's history is very important. The laboratory tests should be summed up before we arrive at a tangible diagnosis. Syphilis, sinus infection, ulcerative stomatitis, ptyalism and industrial diseases should be borne in mind when searching for the etiological factors.

SYMPTOMATOLOGY

Generally there is no local manifestation of pain at the site of the focus in the jawbone. In some cases there is soreness on pressure, and in a few cases pus may be seen discharging from a sinus which communicates with the underlying bone. In many instances healthy gum tissue covers the insidious infection which, to all outward appearances, is benign. We may find a patient suffering of neuralgia, migraine, rheumatism, insanity, chronic appendicitis, hypo or hyper-thyroidism, cardiac lesions, gastric ulcer, etc., and these same pathological changes may be due to focal infection. Empyemia of the sinus may manifest itself by local pain, tenderness, migraine, neuritis or toxemias, discharging nose or the coughing up of pus after a night's rest.

PATHOLOGY

After a flap of overlying soft tissue and periostium is laid back, the jawbone may present a circumscribed area of soft necrotic bone tissue. Generally there is no evidence of pus in or around this area. In our experience the cultures from this bony tissue will return from the laboratory as a streptococcus veridans in practically every instance. Occasionally there is a mixed infection where pus is in evidence. Some areas of necrotic bone are covered by a thin plate of apparently healthy bone and upon chiseling through this plate very frequently the diseased area may be found. Microscopic findings show this diseased tissue to be a mixture of broken down alveolar process, bacteria and detritis. In some cases of infected jawbone the area extends to an adjacent sinus. These sinus

*Presented by Dr. Teifer at the Boston meeting, A. M. A., June, 1921—Section of Stomatology.

infections which may be negative when X-rayed, frequently, at operation, show pus droplets hanging from the walls and the lining membrane partially or totally destroyed.

Dr. Novitzky of San Francisco, recently informed me that Dr. F. E. Blaisdell, director of the laboratory of surgical pathology at the Medical College of Leland Stanford, Jr., University, and himself, completed some very interesting research along the line of bone pathology. The summary of their results is as follows:

"Drainage from a dead root-end could be considered as discharging directly into the blood stream. Fibrous marrow was found underlying all dead teeth examined. Microscopically a diagnosis of Myelitis was always obtainable, while commonly a diagnosis of Osteo-Myelitis was obtainable. The fact that fibrous marrow was present apically and not gingivally, indicates that the irritation producing this scar tissue emanated from the apical part of the root, that is, the apical foramen. In other words, the irritant did not gain access to the marrow thru the gum flap of the mouth. If it did gain access in this way we would expect to see fibrous marrow in all cases near the gingival margin. It cannot be argued that fibrous marrow is due to caustic medicaments inserted into the root canal during dental interference, for it has been demonstrated by others, as welll as observers at Stanford, that fibrous marrow is due to a permanent irritation (infection) and not to a transient trauma.

"Fibrous marrow will be absorbed and normal lymphoid or fatty marrow restored where infection is not present. A nail driven into cancellous bone will cause the formation of fibrous marrow. If asepsis is maintained the fibrous marrow is converted nito normal marrow. This indicated that fibrous marrow at the root ends of dead teeth is due to re-infection and that it is not due to trauma of dental manipulations or of caustic medicaments used during these manipulations."

From the foregoing it is only reasonable to conclude that if the infection adjacent to infected teeth in the bone, sinuses, or soft tissue is not thoroughly removed at the time of the removal of the teeth, or at time of operation for the removal of infection in the jaw or sinus, a chronic irritation is inevitable and fibrous marrow develops in the stead of normal fatty or lymphoid marrow. This chronic irritation (infection) communicates with the blood stream and an organ or organs of lowered vitality are susceptible to metastatic infection, and an arthritis, hyper-thyroidism, gastric ulcer, etc., may be the result.

DIAGNOSIS

A complete case history should be taken on every patient in which we are endeavoring to find the underlying factors in the causation of his disease. This case history should also cover the nature of the dental work; whether the patient has had abscessed teeth or dead teeth removed; the method of removal; whether he has had an acute abscess of a tooth or teeth where the side of the face has been swollen; whether the patient has any recollection of roots having been left in the jaw; the nature of his occupation reference to the industrial diseases; X-rays of both jaws, including areas where teeth have been extracted; whether the patient discharges pus from his nose or coughs up pus in the morning, and by asking the last two questions we will have special reference to sinus infection; the blood counts should be taken; Wassermann tests made; blood sugar tests, and the other routine laboratory measures should be used. When a patient gives the history of having an acute abscess in his jaw and whether or not the tooth has been extracted, you may be reasonably sure to find a myelitis or osteomyelitis in the jawbone around or near that location, even though the X-ray pictures do not suggest the same. In the majority of these cases an exploratory operation will disclose the area. If the same is not evident after laying back a flap of the overlying soft tissue a thin plate of the alveola should be chiseled away and frequently the area will be found by this procedure. We feel justified in using the exploratory method and will attempt to convince you of its therapeutic value.

TREATMENT—SURGICAL

Local or general anesthesia may be used. In local anesthesia the more satisfactory forms are the conductive and infiltration methods. After laying back flaps of the soft tissues the area is generally easily located. If it is not in evidence the bone should be carefully percussed to try and ascertain the location of the necrotic area. In a large series of cases we found 50 per cent of these areas are covered by apparently normal bone.

We feel justified in chiseling the outer plate in the region that is negative on X-raying when the patient gives a history of an acute abscess. No harm will be done if the toothless areas is healthy for the alveolar process will regenerate.

Careful ronguering and curettment should be done, making sure to clean out all of the pathological bone. The operator should not be timid and depend upon the "feel" of the curet to satisfy himself that he has entirely cleaned out the infected area, but should freely expose the area and be sure that he has accomplished the removal of ALL the infection. The area should be carefully probed to determine whether there are any pockets or extensions of the infection. The soft tissues of the flap are then loosely sutured and this will allow sufficient drainage and the wound will generally heal by first intention.

SUMMARY

Improper removal of abscessed teeth is the etiological factor in the majority of cases of edentulous jaw necrosis. Maxillary sinus infection may be a primary or a contributing fac-

tor in the production of jaw infection. The X-ray is valuable aid in suggesting the extent of bone pathology, but too much reliance should not be placed on same. Generally there is no local manifestation of pain at the site of the focus. Some areas are concealed by an outer layer of normally appearing bone. A complete case and dental history should be taken and necessary laboratory tests made. X-rays should be taken of both maxillae, including the edentulous areas. Not infrequently the cause of toxemias of indefinite origin may be found in toothless areas in jaws.

REMARKS

Whether or not the foregoing results were co-incidents or whether my listeners consider this phase of pathology of sufficient import to add to their diagnostic armamentarium is problematical, but it is our sincere wish that latent bone infection in the jaws be given some consideration, and the end results may surprise you when you have searched in vain for a cause of a disease.

The following are a few selected case histories:

No.	Sex	Age	Condition	Mouth	Treatment	Result
1	Female	32	**Neuritis and Neuralgia.** Intermittent for one year.	Edentulous—3 abscessed teeth "pulled" 3 years ago. X-ray suggests bone involvment at site of extraction extending to antrum.	Flap operation — necrotic areas eliminated and antrum drained by oral route.	Relief of all pains instantly. No recurrence in 2 years.
2	Female	60	**Migraine** (Intense)	Edentulous—2 abscessed teeth extracted 15 years ago. X-ray suggests necrotic areas at site of extraction.	Flap operation — areas of infection eliminated.	Relief in two weeks, no recurrence in 2 years.
3	Female	21	**Facial Neuralgia** and **Neuritis** of right shoulder.	All teeth vital—no pyorrhea. Acute abscess of 2 teeth 10 years ago. X-ray suggests infection at sight of one abscess, othr area negative to X-ray.	Flap operation — disclosed necrotic areas at both sites. One negative to X-ray was covered by normally appearing bone. Infection eliminated.	Symptoms disappeared in 12 hours. No recurrence in 18 months.
4	Male	19	**Insane,** for 1½ yrs.	Two abscessed teeth and necrotic area. Acute abscess and extraction 5 years ago. X-ray suggests bone involvement.	Flap operation — Teeth surgically removed and bone infection eliminated.	Gradual improvement in 4 months. No mental exacerbations in 2 years.
5	Male	42	**Iritis** and **Conjunctivitis** intermittently for 10 yrs.	Edentulous mouth. Acute abscess and extraction 10 years ago. X-ray suggests bone involvement at site of extraction.	Flap operation — Necrotic area eliminated.	Symptoms subsided in 10 days. No recurrence in 2½ years.
6	Female	45	**Pyro-Nephitis** and **Gastralgia**	Two abscessed teeth. Necrotic area at edentulous site of acute abscess 4 years ago.	Flap operation — Surgical removal of 2 teeth and necrotic area eliminated.	Gastralgia relieved in 3 days. Urine cleared up in 4 weeks. No recurrence in one year.
7	Male	47	**Gastric Ulcer**	X-ray suggests large tumor under bridge in superior maxilla. Abscessed tooth extracted 4 years ago.	Flap operation — Large cyst removed intact. Bridge not disturbed.	Symptoms subsided in 2 weeks. No recurrence in 2 years.

SIGNIFICANCE OF APPENDICEAL STASIS AS DEMONSTRATED BY THE BARIUM MEAL

WILLIAM A. EVANS, M. D.
DETROIT, MICH.

By far the most important factor in the causation of appendix disease is the disturbance of the function of this structure of expelling its contents. Theoretically, an appendix with normal motility would never become involved in an inflammatory process. Therefore appendiceal stasis becomes the center of interest in the examination of the gastro-intestinal tract with reference to the ileo-caecal region. Of almost equal interest is the association of evidence of disease of the appendix manifested by appendiceal stagnation with the symptom complex of chronic indigestion. There is a very definite relation between abnormal appendix motility and pyrosis, gastric hyperacidity, gastric and duodenal ulcer and constipation, especially of the spastic type.

If I am correct in these statements, the Roentgenologist has a great responsibility when he interprets his appendiceal findings in clinical terms and when he makes recommendations

as to the treatment of the case indicated by the findings.

Consideration of this topic involves the study of the literature pertaining to the anatomical, pathological and physiological aspects of the appendix. All English, French, German and American articles for several years have been referred to. I have gathered from this extensive review:

1. That we do not know whether the appendix is "an organ of physiological involution terminating in obliteration" (1) or whether it is a lymphoid structure with a function analagous to the tonsil.
2. We do not know whether normally Gerlach's valve prevents the entrance of caecal content into the appendix lumen or whether it is quite proper for the appendix to fill by regurgitation from the colon and to take its time in emptying itself.
3. We do not know whether the appendix is concerned with any of the functions of the colon—such as the secretion of Hormones, which control the colonic peristalsis—or whether it functions as an "abdominal tonsil" or whether as an abdominal ductless gland related to the pancreas (2) or whether it is merely a rudimentary or vestigial organ with no responsibility in maintaining bodily health, and,
4. We do not know the exact degree of pathological change that constitutes a "clinical or surgical appendix."

However, from Roentgenological observation and clinical experience, and, with many of us, from personal experience also, we are certain that the whole question of appendix disturbance is bound up with the diagnosis of abdominal organs more or less remote from the appendix.

It is with this relationship that I wish mainly to deal in this paper, both from the standpoint of diagnosis as well as treatment. And in addition, I wish to point out the value of gastro-intestinal studies in infants and children, and that the use of the opaque meal for this field has been overlooked by both clinicians and Roentgenologists alike.

Regarding the vehicle for the administration of the opaque salt with reference to the filling of the appendix, much has been written. George and Leonard believe that buttermilk should be used when appendiceal motility is to be investigated and Skinner supports them in this contention. Our experience includes buttermilk, malted milk and cereals as vehicles, and it is our belief that the appendix fills equally well with either mixture. For the past three years we have used malted milk almost exclusively and it is rarely that we do not observe some barium in the appendix at some time during the study. On a recent afternoon in making the five-hour study, appendix filling was observed in seven consecutive cases.

As to the mechanics, or method of filling the appendix, the entrance of barium into the lumen cannot always be accounted for by gravity or sedimentation, becaues, in many instances, the appendix lies above the caecum, or, at least, its long axis is so placed that the distal portion of the appendix is higher than the proximal. Early filling in the adult can be accounted for by the anatomical relations, but late filling involves the question of anastalsis, or reverse peristalsis. The proximal portion of the large bowel is the only portion of the gastro-intestinal tract which normally has antiperistalsis, and it is because of this movement that the late filling of the appendix occurs.

There is a wide discrepancy in the conclusions drawn as to the clinical or pathological importance of the presence of barium in the appendiceal lumen. Theoretically, the normal appendix should not fill, and for a good anatomical reason, for its opening is protected by a valve, described by Gerlach, which prevents the regurgitation of the caecal contents into the appendix, but permits free passage in the reverse direction. It is the opinion of most Roentgenologists that, in the majority of patients given the barium meal, the appendix is visualized at some time during the observations and that the appendix is not necessarily diseased if barium is found in its lumen. Of far greater importance and of real value is the time, in relation to the ingestion of the barium, that the appendix begins to fill and also the degree of stagnation and the associated pain and tenderness.

In the writer's experience, appendices showing low grade disease usually can be visualized at the second observation, or the five hour study. The visualization of the appendix at this time becomes possible only through careful palpation, for, in the majority of cases, the caecal tip and the appendix region are obscured by the barium in the overlying loops of small bowel.

In a larger percentage of cases, the appendix can be seen at the 24 hour study, and in a much smaller number of cases, the appendix is seen for the first time at the 48 hour study. Barium escapes from the appendix by virtue of its own peristaltic action. When the appendix fills early, the rule is for early emptying. So, of the appendices which are observed on the five hour study, few can be visualized at the end of 24 hours and only rarely one after 48 hours, whereas, of those that are seen outlined with barium at the 24 hour study, many are seen at the end of 48 hours and in those in which the appendix is seen first at 48 hours, stagnation may continue for several days, or even weeks.

There is, therefore, a direct relation between the filling time and emptying time, the curves parallelling, and also a constant relation between the variations of filling time and the degree of pathological changes.

At this point the method of study should be discussed. A correct gastro-intestinal exam-

ination can be made only by using both the screen and plate methods. Plate methods permit of demonstrations of variations in the filling of the lumen, the presence of constrictions or concretions and the differentiation between a large appendix or a loop of terminal ileum. The fluoroscopic method enables one to determine the degree of mobility, to separate the several structures in the ileo-caecal region and to determine with accuracy the organ involved in the right lower quadrant pain and tenderness.

While pericaecal tenderness is not necessarily a constant symptom in appendicitis, pain or discomfort on manipulation is a very common sign. This is especially true in the presence of adhesions or in distention of the lumen. We have classified appendix filling without pain or tenderness as a simple stasis and we have observed that this type of disturbed motility is usually associated with the ordinary gastric hyperacidity without evidence of a gastric or duodenal lesion. If the mere presence of barium in the appendix is not positive evidence of disturbed function or actual disease, it certainly suggests that sooner or later inflammatory changes will ensue, for conditions favorable for development of infection are present, such as an injured mucosa, congestion and other circulatory changes and fibrosis of the appendix walls. One writer has likened the appendix showing stasis to a culture tube with all conditions favorable to germ growth.

Some one has said that chronic appendicitis is always of infantile or early childhood origin and as we study more the gastro-intestinal tracts of the young with a barium meal evidence is accumulating that this observation is correct. Waller (3) and Cole in 1915 made investigation of the prevalence of subacute or chronic appendicitis in children and reported as finding 60 per cent showing signs and symptoms of appendix disease. In children with a history of biliousness or liver trouble, with gaseous distention of the stomach and bowels, or with a record of abdominal cramps or distress, we have usually found appendiceal stasis and at times localized tenderness. Furthermore, in a number of these cases, appendectomy has been done with a relief of all symptoms.

The youngest case in our series was a child of 2 years. There was a history of attacks of abdominal cramps and no other symptoms. A small opaque meal was given. The appendix filled and remained so for 48 hours, with the caecum empty. Appendectomy was done, with complete control of the symptoms.

The procedure of the examination of the child does not vary from that used with the adult. One ounce or less of barium is sufficient and any liquid vehicle is satisfactory.

Variations peculiar to children in the relation of the appendix and caecum, referred to by a number of authors, in our opinion do not exist. We have found that the position of the appendix varies from McBurney's point similarly to that in the adult and that the filling and emptying time variations parallel the adult figures.

There is a very positive relation between the appendiceal stasis and gastric hyperacidity. Formerly increased acidity was considered diagnostic of ulcer, or at least it was strongly suggestive, but it is now known that ulceration of the stomach is relatively rare and that a high acid content means some reflex irritation from a more or less distant lesion or from disturbed function lower in the intestinal tract. The mechanism of this relationsihp will be discussed later.

The frequency of the co-existence of both duodenal ulcer and chronic appendix has often been noted. In our own series, we have observed the double lesion in about 40 per cent of our ulcer cases. Statistics from the Mayo Surgical Clinic show that in over 30 per cent of their duodenal ulcer cases a diseased condition of the appendix was found. As to the explanation of this observation, it is necessary to accept one of two theories. The first is that many ulcers of the duodenum are secondary to metastatic infection from the appendix as a primary focus. The second explanation and the more reasonable one is concerned with the sympathetic enervation of the gastro-intestinal tract and with the gastro-intestinal motility expressed by the term Intestinal Gradient (Alvarez).

Keith has studied the intestinal musculature and nerve tissue in detail, and has developed the theory that "the bundle system of the heart and myenteric plexus of the intestine represent corresponding functional structures." He maintains that a myenteric (Aubach) plexus is not a simple structure composed merely of nerve cells and nerve fibers, but that it is a complex structure with ganglion cells and branching intermediate cells which appear to connect certain groups of muscle cells on one hand and ganglion cells on the other hand. Keith also advances the theory of the presence of sphincteric zones located at various anatomical junctions along the gastro-intestinal canal which control peristaltic activities. The zones are seven or eight in number, and one of them is in the ileo-colic region. Irritation at any of these zones interferes with the intestinal rhythm and spasm is the most common result. There is plenty of Roentgenological evidence that lesions in the ileo-colic region have a profound influence on the musculature of the stomach and duodenum. Pylorospasm, with undue gastric retention, is a common observation.

Under the fluoroscopic screen, the pylorus has been seen to become spastic under manipulation of the appendix. Aaron, in 1915, made a similar observation clinically. And spastic deformities of the duodenum are almost as common as the organic variety and in some cases with well marked appendiceal disease it is quite impossible to properly fill out the duodenal bulb. Now spasm, in addition to mechanically interfering with the gastric and intestinal motility, dsturbs the blood supply to the part irritated, and thus favors the development of ulcers and other lesions.

This brings us to the consideration of the clinical importance of chronic appendix in its relation to the treatment of duodenal ulcer. Since the condition of the appendix is reflected so prominently to the pyloric region of the stomach, influencing strongly both secretion and motility, and since the whole management of duodenal ulcer cases is concerned with the control of gastric secretion and gastric evacuation, it is obvious that any treatment of the duodenal ulcer which does not involve the eradication of a condition which so profoundly affects the reaction of the gastric contents will be futile.

For more than 10 years we have studied from the Roentgen standpoint the progress of the healing of duodenal ulcer under medical treatment, and we have come to the conclusion that it is not possible to properly control duodenal ulcer in the presence of a diseased appendix or in the presence of spastic constipation, and in cases showing these complications we have suggested that indications for treatment from the Roentgen stantpoint would be appendectomy and measures to restore the normal function of the colon, in addition to the treatment of the local lesion itself by the Sippey regime.

Colonic motility is strongly influenced by the appendix, if not entrely controlled from the ileo-caecal region. The reaction may be evidenced both by increased or decreased colonic peristalsis, depending upon the type of disease present in the appendix. If the appendix is adherent or obliterated, its mobility is impaired, and as a result there is no peritoneal reflex and constipation is the result. On the other hand, if the appendix is extremely mobile, the result is peritoneal excitability and consequently acceleration of the bowel movements, even to intermittent diarrhea. However, there are cases of appendix stagnation which appear to be merely secondary to conditions of the caecum, more especially when the relations are disturbed. A ptotic, club shaped caecum or a dilated caecum is often the predisposing factor in appendiceal stasis. In these cases, measures to relieve the underlying factors should be carried out, for appendectomy will not cure the patient. That is, the appendix findings may be signs only of impaired colonic motility. Just as attention to the appendix is necessary to the treatment of gastric and duodenal conditions, so will many cases of constipation or diarrhea go unrelieved as long as the right lower quadrant disease is neglected.

The percentage of patients with clinical and other evidence of appendix disease not relieved by appendectomy is considerable. Gibson (4) reviewed 555 cases and reports that of this number 259 had no complaints, 65 had no symptoms referrable to the appendix and 102 showed no improvement, while 126 were not traced. Thus there were over 20 per cent, at least, who had a condition aside from the lesion in the appendix. Leaving out of consideration the occasional case in which urinary calculus or renal pelvic disease is responsible for the symptoms and also the rare cases when the symptoms of lumbosacral lesions simulate appendix disease, the majority of the failures can be accounted for by other lesions of the gastro-intestinal tract which were induced by the appendix disease or associated with the appendicitis. In a few cases we have been able to demonstrate an appendix stump which retained unduly the barium and which was painful on pressure. In other cases the caecal mucosa is definitely inflamed, and in still other cases, as mentioned previously, disturbed caecal relations, mobility and motility and lesions of the ileo-caecal region were the primary causes of right lower quadrant symptoms and not the appendix disease itself.

In an article by Bennett (5) there appears an explanation of the persistence of pain in the right iliac region after an apparently uncomplicated appendicitis. It is suggested that this pain may be due to a tonic contracton of the ileo-colic muscle, and Grodel has abolished the pain by incising this muscle. It should be stated that the ileo-colic muscle has an intimate connection with the appendix through the posteror longitudinal band.

CONCLUSIONS

1. Sub-actute and chronic appendicitis is common in children and barium meal studies are an important aid in diagnosis.
2. Retention of barium in the appendix lumen is always of diagnostic importance, but not always evidence of active appendicitis.
3. Treatment of hyperacidity, peptic ulcers, constipation and other gastro-intestinal conditions requires the removal of the appendix if this structure shows impaired mobility or motility.

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PERSONAL EXPERIENCES WITH INFANTILE PARALYSIS

RAYMOND G. TUCK, M. D.
(Ex. Capt. M. C. U. S. Army)
BROWN CITY, MICH.

In view of the fact that 98 per cent of all cases of anterio-poliomyelitis occur in children under 15 years of age, and that 75 per cent of these are under 5 years, the thought came to me that, being a physician, I would be able to interpret signs and symptoms with accuracy.

PAST HISTORY

Age, 29 years; married, one child. Had measles, diphtheria, scarlet fever and was wounded while with the army medical corps overseas. At the time I was wounded a shell knocked me unconscious for some time and since that time have noticed that my nervous system seemed to be abnormal. In explanation I can say that whenever anything exciting happens I am subject to palpitation and shaking all over my body. When things did not go just right with me I would break down and cry without being able to control myself. This did not have any effect upon the infantile paralysis. I merely mention the fact to show that my nervous system was below standard.

CLINICAL COURSE

The predominating symptoms were severe sore throat, pain in lumbar region, pain in abdominal region, headache and hyper-sensitiveness of the skin from "Bouparts" ligament down. These symptoms started on Wednesday and the paralysis became apparent early Sunday morning. These symptoms were very similar to those of the "flu" or, as if one were coming down with one of the infectious diseases. My temperature ranged from 100 degrees to 102 degrees.

The first sign of paralysis was noticed when I tried to climb the stairs late Saturday evening, my legs feeling heavy and tired. When I attempted to micturate, after climbing the stairs, I found this impossible and passed a catheter. Sunday morning it was impossible for me to turn over in bed alone and when I attempted to stand upon my feet my legs were absolutely powerless and would not support my weight. I fell in a heap upon the floor and had to be lifted bodily, back into the bed. All day Sunday I was nauseated and vomited fecal matter that night. The most annoying thing with which I had to contend, however, was the great distention from gas. My bowels had not moved since Wednesday.

Monday evening I was taken to the hospital and by patient effort on the part of an orderly my bowels were forced to move. He made use of a large rectal tube, inserting it high up in the rectum. After several attempts I felt something give away low down in the intestinal tract and my bowels moved freely. I am firmly convinced that I had a partial obstruction, or better, perhaps, would be to say temporary obstruction of the lower bowel. The nurse took my temperature about an hour following the bowel movement and it was normal and has remained normal. I really think that I would have continued to grow worse had I not evacuated my bowels. I felt a great deal better and ate breakfast the following morning.

At this time I had an extensive motor paralsis extending from the axilla to the toes, more severe on the right side than on the left. The only motion remaining was flexion and extention of the toes of the left foot. The chest did not show the slightest sign of a rise or fall during respirations, the breathing being entirely diaphragmatic in character. Bowels were moved by using enemata, urine was drawn by catheter. It was necessary to use a catheter for a period of about seven weeks. A most interesting phenomena during this early stage was the gradual recession of the hyper-sensitiveness in the extremities. The interne in the hospital marked this gradual recession by using an iodine swab. It was seen to recede about six inches every 24 hours. The hyper-sensitiveness disappeared entirely by the end of the first week, leaving a muscle soreness upon deep pressure, more pronounced in extensor groups of the leg. I am told, by one who had infantile paralysis 12 years ago, that this soreness in the calves of the legs still persists after all that time. The knee joints were very painful when over-extended. Splints of plaster paris were fitted to each leg, keeping the feet held at right angles. These splints were made similar to a trough and my legs were taken out every day and massaged.

Spinal fluid showed clear with an increased cell count. Wassermann reaction negative. Blood count showed a slight increase in leucocytes. Heart sounds were normal, but my pulse was fast (90-100). Breathing was labored at times, due to so much distention of abdomen. Sleep much disturbed. The medication given at this time was uritone intravenously, codiene sulph. grs. one every night.

PROGRESS

"The changes begin, as can be studied in

experimental animals and in the cases which end fatally in the early stages with hyperaemia of the pia and of the blood vessels which pass into the cord through the anterior fissure and with the accumulation of lymphocytes and polymorphoneculear leucocytes about them. This process quickly extends into the substance of the cord, and not only into the gray matter of the anterior horn cells, as was formerly thought, but everywhere the small arteries and venules are found surrounded with a mantle of such cells. Many writers try to show that the mechanical effect of the inflammation causes the injury to the ganglion cells, but it seems more probable that it is the direct result of the presence of the infective agent."

This same pathologist also points to other very interesting changes, namely: Minute focal necroses of the liver cells with an accumulation of lymphocytes. The lymph glands are also affected with this necrosis and resemble closely the glands in typhoid fever. Cloudy swelling of the liver and kidneys is usual. The fact that this disease belongs in the classification of the acute infections is now accepted by most of our leading authorities.

It is a known fact that during epidemics many persons are infected, but not all have the attending paralysis. This explains why so many do not contract the disease as they have, perhaps, had it at some time previous and have an established immunity. That it is spread by contact also seems to have been proven and in my own case I am sure that I contracted the infection from one who was coming down with it. The person with whom I came in contact died a few days following and her case was diagnosed by one of recognized standing as an internist. I became afflicted about one week or ten days following this contact with the disease. A mild epidemic was noticed in that section of the state.

Just as soon as the soreness had left my legs enough for me to stand gentle massage I was given physio-therapy, which consisted of heat applied to the affected parts by using a thermo lamp and Burdick baker, after which massage was given very gentle at first, and gradually increasing the pressure. Following the massage each muscle was caused to go through the normal movements, being aided by the attendant or aide. The massage was given with the motion at all times towards the heart with the object in view of emptying the veins and they would then receive a fresh supply of blood and give more nourishment to the afflicted parts. The muscles that had very little strength were assisted in going through their movements by the aide and after a few weeks strength could be seen returning to the muscle and it would function without assistance. These exercises were repeated 10 times every day. A feeling of restful fatigue was experienced following each treatment. Muscle tests were conducted once every three months and where one group of muscles showed stronger than their opposing group the opposing group was given more massage and exercise until they were as strong as the other. An example of this was when the extensor group of the legs became very strong and had a tendency to keep feet extended, but by patient effort and repeated exercise the flexors began to regain their strength and overcome the pulling of the extensors. While this was going on the extensor group were not allowed to exercise.

The abdominal muscles were constantly on the stretch while I was prone in bed and did not show much sign of returning to function until after I had begun sitting up and taking the stretch off them. This showed that any muscle that is allowed to remain constantly on a stretch will never return to normal and in the management of a case this should always be avoided. Get the patient sitting up in bed just as soon as it is possible, as this prevents the patient from becoming so debilitated. The friction of the bed clothes made it impossible to adduct or abduct the legs, so the aide had to place her hand under the heel of the foot and then I could swing the legs outward and inward. After a few weeks, resistance was applied until I could complete these movements against the resistance of the bedclothes.

I was advised against weight bearing during the first year and tried to follow this advice, although it was quite trying at times not to endeavor to walk. At first I only touched my feet to the floor and then after a week or two put a little more weight upon them. Then, when the legs got accustomed to bearing my weight, I tried taking a few steps along the side of the bed. After about one month of walking along the side of the bed, once a day, I had made a frame of gas pipe with castors underneath and by holding onto this frame I walked across the room and back once a day. This frame gave me greater confidence than anything I could have used as it was impossible to fall when walking and that was what terrified me most of anything. The last muscle test showed weak abdominals, weak lumbar and weak right hip groups. Those muscles had always been weaker than the rest, in comparison, and they were all given special massage and exercises every day with the result that at the present time I can walk fairly well, using crutches, and can walk by making use of two canes. This is at the end of the twenty-second months and I am told that the maximum gain is not to be expected until the expiration of three years. I am improving every day and think that by the end of the

three-year period that I will be able to walk almost as well as ever. The back and hip muscles continue to gain strength the more they are exercised. Every muscle in my body shows a return of function and I cannot see why, with increased exercises, they will not return to normal function, or at least almost normal.

COMMENTS

It is not to be wondered at that the people turn first to one physician, then to another, and finally end up with the quack. In my own case one specialist in orthopedics told my wife and friends that I would be bedridden all the remainder of my life. How he knew so positively I am unable to state, yet he was making such a discouraging prognosis without being able to tell exactly how much destruction had been caused in the cord. One thing that cases do need, and need lots of, is optimism.

One other "orthopod" advised immediate weight bearing and as much exercise as it was possible to give. He recommended making use of a bath tub filled with tepid water and overcome the resistance of gravity this way. Another younger man was asked what he thought was the best form of treatment and this is what he wrote:

First of all, prevent deformities from occurring; this is brought about by proper splints. The muscles should be kept in as good condition as possible in anticipation of the return of nerve stimulation. This is done by cautious massage and exercises. One point to remember is to not over-tire the muscles. If you discover, for instance, that you can work your great toe, which has been paralyzed, don't be so tickled that you work it to death, for that happens. Be patient, be gradual, be systematic. Keep the joints supported so that the paralyzed muscles will not be kept on the stretch, then systematically develop the strength of them. This, in a few words, describes what was done in my case.

It seems to me that where there is such a diversified opinion among several recognized specialists concerning a mode of treatment, something could be done to get at the right and wrong of things. For wrong some of them surely are. I am not attempting, far be it from such, to advise my elders in what they should do, but I do wish to advise them that they are all possessed of different ideas concerning the management of a case of infantile paralysis.

If specialists cannot agree upon such a thing, what about your students and general practitioner, who sort of look to these men for guidance and advice. It is the poor unfortunate who has become afflicted, who suffers. I am satisfied that the world would contain fewer crippled and deformed children, were the proper treatment employed by the profession at large. It surely is time something was done to remedy this blundering.

"THE CLIQUE"

A friendly contributor sends in the subjoined rhyme, which he describes as "not exactly a masterful piece of literature, but a jingle which fits some occasions." It was clipped, but neither its original source of authorship nor of publication are now known.

THE CLIQUE

What is the Clique? 'Tis those who attend
All of the meetings, on whom we depend.
They never are absent unless they are sick—
These are the ones the grouch calls "The Clique."

These are the ones who are never behind in their dues,
Who come to the meetings and have their own views.
They'll serve on committees and never say die;
"The Clique" are the ones that always "get by."

We all should be proud of members like these—
You can call them "The Clique" or whatever you please.
They never attempt any duties to shirk—
These are "The Clique," that do most of the work.

But there are some people who always find fault,
And most of this kind are not worth their salt.
They like to start trouble, they seldom will stick;
They like to put all the work on "The Clique."

Program of the 103rd (58) Annual Meeting of the Michigan State Medical Society, Grand Rapids, September 11th, 12th and 13th, 1923

OFFICIAL CALL

The 103rd Annual Meeting, (58th since reorganization) of the Michigan State Medical Society, its Council and House of Delegates will be held in Grand Rapids, September 11, 12 and 13, 1923, for the transaction of official business that properly comes for consideration under the provisions of our Constitution and By-laws.

W. T. DODGE, President.
A. L. SEELEY, Chairman of the Council.
CARL MOL, Speaker of the House of Delegates.

Attest: F. C. WARNSHUIS, Secretary.

MEETING PLACES

GENERAL HEADQUARTERS, REGISTRATION AND EXHIBITS—Pantlind Hotel.

HOUSE OF DELEGATES—Auditorium, Parish House, Park Congregational Church.

MEDICINE—Junior Room, Park Congregational Church.

SURGERY—Main Auditorium, Park Congregational Church.

GYNECOLOGY—Parish House Auditorium, Park Congregational Church.

EYE, EAR, NOSE AND THROAT—Children's Auditorium, Park Congregational Church.

PEDIATRICS—Gymnasium, Park Congregational Church.

PUBLIC HEALTH—United Workers' Room, Park Congregational Church.

REGISTRATION—Pantlind Hotel.

EXHIBITS—Ballroom, Pantlind Hotel.

LOCATION OF MEETING PLACE

Park Congregational Church is located at the corner of Park avenue and Library street, opposite the Fulton street park.

From the Pantlind Hotel, walk east, up Monroe avenue, five blocks until you come to Fulton street. Park Church will be seen, just across the park, on the east. Facing on the park are also the Evening Press Building, the Ryerson Public Library and the Y. M. C. A.

MEETINGS

September 11th.

12:00 M. Council Meeting.
2:00 P. M. First Session of House of Delegates.
7:30 P. M. Second Session of House of Delegates.
9:00 P. M. Smoker—Peninsular Club.

September 12th.

8:00 A.M. House of Delegates.
9:45 A. M. General Meeting.
1:15 P. M. Section Meetings.
8:30 P. M. President's Reception and Entertainment by the Kent County Medical Society at Kent Country Club.

September 13th.

8:00 A. M. House of Delegates.
9:15 A. M. Section Meetings.
11:30 A. M. General Meeting.
1:15 P. M. Section Meetings.
4:30 P. M. Adjournment.

HOTELS

Pantlind Hotel—General Headquarters.
Hotel Rowe.
Livingston Hotel.
Hotel Mehrtens.
Hotel Crathmore.
Hotel Cody.

COMMITTEES

ON ARRANGEMENTS—Kent County Medical Society.

EXECUTIVE—General Chairman, Dr. Burton R. Corbus; Chairman of Sub-Committees, Dr. James Brotherhood.

MEETING PLACES—Dr. Alden Williams.
FINANCE—Dr. Frank C. Kinsey.
EXHIBITS—Dr. Verne Wenger.
ENTERTAINMENT—Dr. A. M. Campbell.
LADIES—Dr. Faith Hardy.
RECEPTION—Dr. C. C. Slemons.
HOTELS AND RESERVATIONS—Dr. F. C. Warnshuis.
AUTOMOBILES—Dr. S. L. O'Brien.

ADDRESSES BY OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION

By invitation of the President and the Council, the following officers of the American Medical Association will be present at our Grand Rapids meeting and will address the House of Delegates at the evening session of the House on September 11th.

Dr. George H. Simmons, General Manager and Editor.

Dr. Olin West, Secretary.

Dr. Woodward, Executive Secretary, Legislative Bureau.

These national officers will have a message that will convey that which our American Medical Association is accomplishing.

GENERAL MEETING

FIRST SESSION

TIME: Wednesday, 9:45 A. M.

PLACE: Main Auditorium, Park Congregational Church.

W. T. Dodge, Big Rapids, President.
F. C. Warnshuis, Grand Rapids, Secretary.

1. Call to Order.
2. Invocation—Rev. C. W. Merriam, Park Congregational Church.
3. Address of Welcome—R. J. Hutchinson, President, Kent County Medical Society.

4. Announcements—Burton R. Corbus, Chairman, Local Committee on Arrangements.
5. Report from the House of Delegates by the Secretary.
6. President's Annual Address—W. T. Dodge, Big Rapids.
7. Address—Honorable Woodbridge N. Ferris, United States Senator.
8. Address—Rev. Alfred W. Wishart, Grand Rapids, Mich.
9. Nominations for President for ensuing year.
10. Resolutions.
11. Adjournment.

GENERAL MEETING

SECOND SESSION

TIME: Thursday Morning, 11:30 A. M.
PLACE: Main Auditorium, Park Congregational Church.

1. Call to Order.
2. President's Remarks.
3. Resolutions and Unfinished Business.
4. Report From House of Delegates.
5. Report on Ballot for President.
6. Introduction of new President.
7. Adjournment.

COUNCIL MEETINGS

The Council will hold the following meetings:

September 11—12:00 M.
September 11—5:00 P. M.
September 12—12:00 M.
September 13—12:00 M.
A. L. Seeley, Chairman.

HOUSE OF DELEGATES

Carl Mol, Flint, Speaker.
F. C. Warnshuis, Grand Rapids, Secretary.

FIRST SESSION

TIME: September 11, 2:00 P. M.
PLACE: Parish House, Park Congregational Church.

1. Call to Order and Roll Call.
2. Speaker's Address—Carl Mol, Flint.
3. President's Address—W. T. Dodge, Big Rapids.
4. Appointment of Business Committee by the Speaker.
5. Election of Nominating Committee. (See Foot Note).
   (No two members to be elected from the same Councillor Districts).
6. Reports of Committees.
   (a) Council.
   (b) Tuberculosis.
   (c) Civic and Industrial Relations.
   (d) Legislation and Public Policy.
   (e) Revision of Constitution and By-Laws.
   (f) Delegates to the A. M. A.
   (g) Special Committees.
   Joint Education.
   Advisory to State Health Commission.
7. New Business and Resolutions.
8. Adjournment to Evening Session.

Foot Note: Duties of Nominating Committee:
(a Nominate First, Second, Third and Fourth Vice Presidents.
(b) Nominate place for next Annual Meeting.
(c) Nominate Two Delegates and Two Alternates to the American Medical Association to succeed A. W. Hornbogen and J. D. Brook, terms expiring.
(d) Nominate Councillors to succeed following Councillors, whose terms expire:
Second District—L. W. Toles, Lansing.
Fourth District—J. B. Jackson, Kalamazoo.
Fifth District—W. J. DuBois, Grand Rapids.
Eighth District—A. L. Seeley, Mayville.
Ninth District—F. B. Holdsworth, Traverse City.
Tenth District—J. McLurg, Bay City.
Twelfth District—R. S. Buckland, Baraga.
Fourteenth District—C. T. Southworth, Monroe.
(e) Supervise Ballot for President.

SECOND SESSION

TIME: September 11, 7:30 P. M.

1. Roll Call.
2. Unfinished Business.
3. New Business and Resolutions.
4. Report of Business Committee.
5. Report of Special Committees.
6. Adjournment.

THIRD SESSION

TIME: September 12, 8:00 A. M.

1. Roll Call.
2. Report of Business Committee.
3. New Business.
4. Report of Special Committees.
5. Adjournment.

FOURTH SESSION

TIME: September 13, 8:00 A. M.

1. Roll Call.
2. Final Report of Business Committee.
3. Unfinished Business.
4. Report of Nominating Committee.
5. Elections.
6. Resolutions.
7. Adjournment, Sine Dei.

DELEGATES AND ALTERNATE DELEGATES HOUSE OF DELEGATES

NOTE—The blackface type that of the Delegates: the lightface type that of the alternate.

ALPENA—Branch No. 48
ANTRIM-CHARLEVOIX-EMMETT—Branch No. 41

F. Grillette, Alanson.
Harry E. Shaver, Boyne City.
B. H. Van Leuvan, Petoskey.
R. D. Engle, Petoskey.

BARRY—Branch No. 26

Guy Keller, Hastings.
Fred Andrews, Woodland.

BAY—Branch No. 4

A. J. Zaremba, Bay City.
P. R. Urmston, Bay City.
G. W. Moore, Bay City.
M. Gallagher, Bay City.

BENZIE—Branch No. 59
BERRIEN—Branch No. 50

Robert Henderson, Niles.
R. N. Dunnington, Benton Harbor.

BRANCH—Branch No. 9

W. A. Griffith, Coldwater.
F. H. Harris, Coldwater.

CALHOUN—Branch No. 1

W. S. Shipp, Battle Creek.
C. S. Gorsline, Battle Creek.
E. L. Parmeter, Albion.
W. L. Godfrey, Battle Creek.

CASS—Branch No. 36
CHEBOYGAN—Branch No. 58
CHIPPEWA-LUCE-MACKINAW—Branch No. 35
CLINTON—Branch No. 39

W. A. Scott, St. Johns.
F. E. Luton, St. Johns.

DELTA—Branch No. 38

H. J. Defnet, Escanaba.
A. H. Miller, Gladstone.

DICKINSON-IRON—Branch No. 56
EATON—Branch No. 10

C. L. McLaughlin, Vermontville.
Stanley Stealey, Charlotte.

GENESEE—Branch No. 24

J. C. Benson, Flint.
Carl Moll, Flint.
D. D. Knapp, Flint.
W. H. Winchester, Flint.

GOGEBIC—Branch No. 52

H. A. Tressel, Wakefield.
T. S. Crosby, Wakefield.

GRAND TRAVERSE-LEELANAU—Branch No. 18
GRATIOT-ISABELLA-CLARE—Branch No. 25

C. F. Dubois, Alma.
E. F. Lamb, Alma.

HILLSDALE—Branch No. 3

W. H. Sawyer, Hillsdale.
W. H. Ditmars, Jonesville.

HOUGHTON—Branch No. 7

Alfred Labine, Houghton.
A. D. Aldrich, Houghton.
W. K. West, Trimountain.

HURON—Branch No. 47
INGHAM—Branch No. 40
IONIA-MONTCALM—Branch No. 16

F. J. Fraleck, Greenville.
J. J. McCann, Ionia.

JACKSON—Branch No. 27

H. A. Brown, Jackson.
E. F. Lewis, Jackson.

KALAMAZOO—Branch No. 64

A. W. Crane, Kalamazoo.
W. E. Collins, Kalamazoo.
B. A. Shepard, Kalamazoo.
J. C. Maxwell, Paw Paw.
R. A. Morter, Kalamazoo.
W. O. Vaughan, Plainwell.

KENT—Branch No. 49

C. C. Slemons, Grand Rapids.
A. V. Wenger, Grand Rapids.
A. Williams, Grand Rapids.
J. D. Brook, Grand Rapids.
H. J. Pyle, Grand Rapids.
Wm. Wilson, Grand Rapids.
E. N. Nesbitt, Grand Rapids.
A. H. Edwards, Grand Rapids.

LAPEER—Branch No. 23

D. J. O'Brien, Lapeer.
N. D. McVicar, Imlay City.

LENAWEE—Branch No. 51
MACOMB—Branch No. 48
MANISTEE—Branch No. 19

H. D. Robinson, Manistee.
A. A. McKay, Manistee.

MARQUETTE-ALGER—Branch No. 28
MASON—Branch No. 17
MECOSTA—Branch No. 8

G. H. Yeo, Big Rapids.
J. B. Campbell, Big Rapids.

MENOMINEE—Branch No. 55
MIDLAND—Branch No. 43

J. H. Sherk, Midland.
C. V. High, Midland.

MONROE—Branch No. 15
MUSKEGON—Branch No. 61

F. B. Marshall, Muskegon.
S. G. Cohan, Muskegon.

NEWAYGO—Branch No. 50
OAKLAND—Branch No. 3

Geo. P. Raynale, Birmingham.
P. D. Hilty, Birmingham.

O. M. C. O. R. O.—Branch No. 11
ONTONAGON—Branch No. 66

E. J. Evans, Ontonagon.
F. W. Machugh, Ontonagon.
W. B. Hanna, Mass City.
J. S. Nitterauer, Ontonagon.

OSCEOLA-LAKE—Branch No. 30
OTTAWA—Branch No. 32

R. H. Nichols, Holland.
W. Westrate, Holland.

PRESQUE ISLE—Branch No. 63
SAGINAW—Branch No. 14

C. H. Sample, Saginaw.
W. J. O'Rielly, Saginaw.

SANILAC—Branch No. 20

W. J. McColl, Croswell.
W. T. Atkinson, Marlette.

SCHOOLCRAFT—Branch No. 57

W. K. Wright, Manistique.
J. W. O'Neil, Manistique.

SHIAWASSEE—Branch No. 33
ST. CLAIR—Branch No. 45
ST. JOSEPH—Branch No. 29
TRI—Branch No. 42

John F. Gruber, Cadillac.
S. C. Moore, Cadillac.

TUSCOLA—Branch No. 29

O. G. Johnson, Fostoria.
J. T. Redwine, Cass City.

WASHTENAW—Branch No. 42

John A. Wessinger, Ann Arbor.
Warren E. Forsythe, Ann Arbor.
John A. Wessinger, Ann Arbor.
Udo J. Wile, Ann Arbor.
Harold Barss, Ann Arbor.

WAYNE—Branch No. 2

George Sewell, Detroit.
Raymond L. Clark, Detroit.
J. E. King, Detroit.
George E. Frothingham, Detroit.
Clark D. Brooks, Detroit.
Harry M. Malejan, Detroit.
Raymond C. Andries, Detroit.
George M. Livingston, Detroit.
George C. Chene, Detroit.
Ray Connor, Detroit.
Charles F. Kuhn, Detroit.
Harold K. Shawan, Detroit.
Wm. J. Cassidy, Detroit.
E. Wilber Caster, Detroit.
J. Walter Vaughan, Detroit.
Walton K. Rexford, Detroit.
James E. Davis, Detroit.
Frank A. Kelly, Detroit.
Guy L. Connor, Detroit.
J. Albert Kimzey, Detroit.
Archibald D. McAlpine, Detroit.
Norman A. Allen, Detroit.
B. H. Larsson, Detroit.
George K. Sipe, Detroit.
Henry A. Luce, Detroit.
Ralph K. Johnson, Detroit.
Albert E. Catherwood, Detroit.
John E. Gleason, Detroit.
H. Wellington Yates, Detroit.
Wm. M. Donald, Detroit.
Ledru O. Geib, Detroit.
Gerald H. McMahon, Detroit.
F. D. Royce, Detroit.
John L. Chester, Detroit.
Wyman D. Barrett, Detroit.
J. Hamilton Charters, Detroit.
Louis J. Morand, Detroit.
George C. Burr, Detroit.
Edward H. Sichler, Detroit.
C. Hollister Judd, Detroit.
Roger V. Walker, Detroit.
Wm. Stapleton, Detroit.
C. Fremont Vale, Detroit.
Douglas L. Gordon, Detroit.
Howard W. Peirce, Detroit.
Don A. Cohoe, Detroit.
Guy L. Kiefer, Detroit.
Beverly D. Harison, Detroit.
Richard M. McKean, Detroit.
Henry L. Ulbrich, Detroit.
Angus McLean, Detroit.
Harry L. Clark, Detroit.

SECTION ON MEDICINE

Chairman—John L. Chester, M. D., Detroit.
Secretary—Frank J. Sladen, M. D., Detroit.

FIRST SESSION

September 12, 1923, 1:00 P. M.

1. Diagnostic and Therapeutic Considerations in Pulmonary Tuberculosis.

   Lawrason Brown, M. D., Saranac Lake, N. Y.

2. A City Program for the Control of Tuberculosis.

   A. M. Wehenkel, M. D., Detroit.

   Synopsis: The chief factors in a campaign against tuberculosis.
   The relationship with private physicians.
   The part of the sanatorium, the preventorium and the open air schools in a successful campaign against tuberculosis.

3. Sinus Disease and Lung Infections.

   Kennon Dunham, M. D., Cincinnati, Ohio.

   Synopsis: Difficulty of differentiating tuberculous from non-tuberculous lesions. Regard all incipient lung lesions as a focal infection. Three hundred and eighty-nine tuberculous suspects analyzed. Twenty-eight per cent primary focus elsewhere. Infected sinus with no symptoms a frequent finding in both tuberculous and non-tuberculous cases. X-ray diagnosis of chest. Relief from clearing sinus infection.

Discussion of these three papers by:

Dr. Herbert M. Rich, Detroit.
Dr. A. B. Wickham, Detroit.
Dr. William J. Kay, Lapeer.
Dr. B. A. Shepard, Oshtemo.
Dr. W. H. Marshall, Flint.
Dr. John T. Sample, Saginaw.
Dr. Leo C. Donnelly, Detroit.
Dr. C. C. Slemons, Grand Rapids.
Dr. R. M. Olin, Lansing.

4. Auricular Fibrillation and Its Treatment.

   Frank N. Wilson, M. D., Ann Arbor.

   Synopsis: Auricular fibrillation occurs in mitral stenosis, toxic goitre, and chronic myocarditis. It occurs in other conditions occasionally, but most of the cases fall into these three groups. The most common irregularity in patients with cardiac failure. It may be treated with digitalis which does not abolish the irregularity but increases the efficiency of the heart by slowing the ventricular rate; with quinidin which abolishes the irregularity in about 50 per cent of the cases. Quinidin, however, frequently causes accidents which prohibits its indiscriminate use. In a few cases it proves of great benefit but the cases to which it is given must be selected with great care if disaster is to be avoided.

5. The Typing of Arterial Hypertension As a Basis for Treatment.

   Frank J. Sladen, M. D., Detroit.

   Synopsis: High blood pressure a frequent finding. Attitude of physician. Reaction of patient. Mental state. Other causes. Relationship to diet. Experimental work. Three types. Method of typing. Determination necessary in experimental work. Type determines treatment. Form of treatment according to type.

Discussion of these two papers led by:

Dr. M. A. Mortenson, Battle Creek.
Dr. Walter J. Wilson, Detroit.
Dr. Alpheus Jennings, Detroit.
Dr. F. Janney Smith, Detroit.
Dr. William Northrup, Grand Rapids.

6. The History and the Metabolism of Diabetes Mellitus.

   Bruce C. Lockwood, M. D., Detroit.

   Synopsis: Discovery of diabetes. Cycles through which dietetic treatment has passed. Recent metabolic researches regarding ketosis.

7. The Use of Insulin in the Treatment of Diabetes Mellitus.

   Phil L. Marsh, M. D., Ann Arbor.

   Synopsis: Indications for use of insulin. Importance of diet. Insulin in severe diabetes. Balance between dose and diet. Insulin in coma, infection and surgery. Causes, symptoms and treatment of overdose.

Discussion of these two papers led by:

Dr. Leonard F. C. Wendt, Detroit.
Dr. Irvine McQuarrie, Detroit.
Dr. Burton R. Corbus, Grand Rapids.
Dr. Paul Roth, Battle Creek.

SECOND SESSION

September 13, 9 A. M.

Chairman's Address.

1. The Dangers and Duties of the Hour in Medical Practice. John L. Chester, M. D., Detroit.

   Synopsis: The present. A departure from old traditions and ethics. Unrest within. Public suspicious.

   The state of public health. War-time findings and experiences. New perspective in practice. Periodical health examination. Need for. How

to be made. Necessity of a general campaign therefor.

The family physician. His status in all medical matters. His relationship with family.

Periodical health examination or state medicine. Clear issue is present. The duty of the profession.

Physicians' remuneration. Personal matter between practitioner and patient. No concerted movement to fix fees.

Group practice. Personnel. Reason for. Modus operandi.

The future. Plea for return to time-honored ethics. Necessity for acquiring knowledge and rendering service.

2. Transient Paralysis. Their Diagnosis and Treatment. C. G. Jennings, M. D., Detroit.

Synopsis: Transient aphasias and paralyses of central origin form a neurological group of great interest to the medical practitioner—Transient aphasias most common—Monoplegias and sensory disturbances frequent—Pathology of transient paralysis has been subject of much interested discussion—Condition occurs as a complication in hypertension and arteriosclerosis—Causes of major apoplectic attacks, hemorrhage, thrombosis and embolism not adequate to account for paralytic symptoms of very short duration. Spasm of the cerebral vessels or localized oedema of the brain thought to be the pathological basis of some attacks—Partial occlusion by soft thrombus most reasonable explanation—Diagnosis—Prognosis—Treatment.

3. The Definition of Psychoneurosis and Fundamental Points in Treatment.
Thomas J. Heldt, M. D., Detroit.

Synopsis: Psychoneurosis a definite term. Criteria for use. Symptomatology and objective signs. Basis for therapy and purpose. Features of treatment.

Discussion of these two papers led by:

Dr. H. A. Reye, Detroit.
Dr. A. L. Jacoby, Detroit.
Dr. Carl D. Camp, Ann Arbor.
Dr. David Clark, Detroit.
Dr. Frank R. Starkey, Detroit.
Dr. Bertram A. Jones, Detroit.

4. Basal Metabolism from the Standpoint of the Clinical Laboratory, with Remarks Upon Treatment, Based Upon the Study of Five Hundred Cases.
Harry L. Clark, M. D., Detroit.

Synopsis: Basal metabolism determinations, properly made, are of value in:

1. The differential diagnosis of thyroid diseases and of other diseases effecting the metabolic rate.
2. In determining the severity of the disease.
3. In ascertaining the effect or therapeutic measures both medical and surgical.

The cases which have come under our observation will be grouped and a brief discussion of the therapeutic measures indicated by our findings will be given.

Discussion led by:

Dr. William R. Vis, Grand Rapids.
Dr. Frank W. Hartman, Detroit.
Dr. Paul Roth, Battle Creek.
Dr. George M. Kesl, Port Huron.
Dr. O. A. Brines, Detroit.

5. Bronchial Asthma.
A. D. Wickett, M. D., Ann Arbor.

Synopsis: The need of more thorough examination of asthmatics. The results of treatment.

Discussion led by:

Dr. Herbert M. Rich, Detroit.
Dr. Frank R. Menagh, Detroit.
Dr. James R. Brotherhood, Grand Rapids.
Dr. Douglas Donald, Detroit.
Dr. Newell S. Ferry, Detroit.
Dr. Robert B. Harkness, Houghton.

6. The Present Status of the Etiology of Chronic Arthritis With Remarks Upon Treatment.
L. M. Warfield, M. D., Ann Arbor.

Synopsis: Due to the many changes which occur in and about the joints it has been difficult to classify the cases of chronic arthritis. A working classification is given based upon physical signs and X-ray findings.

The part that focal infection plays and the evident exceptions.

Some illustrative cases with lantern slide demonstration.

Discussion of the treatment of these protracted cases by medicinal and mechanical means.

7. Nonspecific Protein Therapy in Arthritis.
William S. Petersen, M. D., Chicago.

Synopsis: Nonspecific agents and the reaction they cause. General reaction. Focal reaction. Experience in arthritis. Form of foreign protein to be used. Relation to carditis. Comparison with ordinary treatment. Results.

Discussion of these two papers led by:

Dr. C. W. Peabody, Detroit.
Dr. Stewart Wilson, Detroit.
Dr. Paul G. Wooley, Detroit.
Dr. Edward A. Spalding, Detroit.
Dr. Richard M. McKean, Detroit.
Dr. E. W. Haass, Detroit.

THIRD SESSION

September 13, 1 P. M.

Election of Chairman.

1. The Present Status of the Treatment of Disease With Organ Extracts.
Ernest E. Irons, M. D., Chicago.

Discussion led by:

Dr. Robert C. Moehlig, Detroit.
Dr. Hugo Freund, Detroit.
Dr. S. Merrill Wells, Grand Rapids.
Dr. Julian L. Kendall, Detroit.
Dr. Joseph B. Whinery, Grand Rapids.
Dr. Plinn F. Morse, Detroit.

2. The Diagnostic Value of the Gastric Secretion.
Martin E. Rehfuss, M. D., Philadelphia.

3. Gastric Obstruction.
C. Emerson Vreeland, M. D., Detroit.

Synopsis: Types of gastric obstruction. Causes and differential diagnosis. Indications for surgical interference. Opportunity for medical treatment.

4. A Study of the Diagnostic Criteria of Duodenal Ulcer. John G. Mateer, M. D., Detroit.

Synopsis: From the standpoint of diagnosis any large group of peptic ulcer cases may be subdivided into four groups. This study includes a rather large group of cases of simple duodenal ulcer without organic pyloric obstruction. Characteristic ulcer history ranks first as a diagnostic measure in peptic ulcer. Carefully conducted X-ray studies easily rank second in the diagnosis. Such studies are not only of value in confirming the clinical diagnosis of ulcer, but also in yielding information as to the exact location and character of the ulcer, thereby making possible the selection of the best type of treatment for the individual case. In X-ray studies it is extremely important to distinguish between intrinsic and extrinsic spasm of duodenal bulb. Indirect X-ray evidence is chiefly of confirmatory value. Epigastric tenderness was found in 53 per cent of the cases. It has limited value in differential diagnosis. Occult blood in stool was found in 25 per cent of cases. With fractional gastric analysis 67 per cent of cases showed a gastric hyperacidity, 29 per cent a normal acidity, and four per cent a sub-acidity. In individual cases gastric analysis findings are of limited diagnostic importance.

5. Clinical Alkalosis in Gastric Disease.
J. B. Youmans, M. D.
I. W. Greene, M. D., Ann Arbor.

Synopsis: Occurrence and clinical significance of alkalosis. Not fully appreciated. Brief discussion of conditions under which alkalosis occurs. The occurrence of alkalosis in gastric disease with and without tetany. Clinical significance of pretetany alkalosis. Abstracts of illustrative cases. Significance of findings.

6. Certain Factors Which Should Be Considered When Prognosing the Cure of Peptic Ulcer.
Frank R. Smithies, M. D., Chicago.

Discussion of these five papers led by:

Dr. Frederick G. Buesser, Detroit.
Dr. A. S. DeWitt, Detroit.
Dr. John T. Watkins, Detroit.
Dr. W. H. Enders, Jackson.
Dr. A. W. Crane, Kalamazoo.
Dr. Collins H. Johnston, Grand Rapids.
Dr. Mark Marshall, Ann Arbor.
Dr. Charles D. Aaron, Detroit.
Dr. E. L. Eggleston, Battle Creek.

SURGICAL SECTION

Chairman—F. B. Walker, Detroit.
Secretary—A. C. Blakeley, Flint.

FIRST SESSION

September 12, 1:15 P. M.

1. Chairman's Address.
F. B. Walker, Detroit.
2. Traumatic Injuries of the Head.
H. E. Randall, Flint.

(a) The heavy mortality in this class of injury.
(b) Indications are definite when and when not to operate.
(c) Never operate in shock.
(d) Typical symptoms of brain injury.
(e) Depressed and G. SW. wounds.
(f) Methods of examination—X-ray, Eye, Pulse Rate and Pressure, Spinal Pressure.
(g) Decompression operations.
(h) Comment on symptoms following head injuries—Headache, unconsciousness, irritability, pulse rate and pressure, etc.

3. Diseases of the Spinal Cord.
Max Ballin, Detroit.
4. The Value of Enterostomy in Surgery.
C. D. Brooks, Detroit.

Enterostomy holds the same place in the reduction of mortality and morbidity in proper cases as does the two-stage operation for prostatic hypertrophy.

Many cases of acute peritonitis which have extended for several days, have had their lives saved by enterostomy at the time of the operation.

This procedure is also of value in operations on Neoplasms, of the large colon, either performed as a preliminary operation or at the time of the resection of the neoplasm. It is also of value in treatment of inoperable carcinoma of the rectum, with radium, etc.

5. A Study of the Chemical Solvents Used in Dissolving Foreign Bodies in the Urinary Bladder, Such as Paraffin, Beeswax, Gum and Urethral Pencils.
Harold L. Morris, Clarence I. Owen, Detroit.

The impossibility of grasping foreign bodies of this character with the ronguer, lithrotrite, or other bladder instruments prompted this study which consisted of establishing the known dissolvents in vitro, then, by means of animals to satisfactorily determine the solvents that could be used in vivo, the observations being reported in detail.

SECOND SESSION

September 13, 9:00 A. M.

1. Impressions of European Proctology.
L. J. Hirschman, Detroit.
2. Management of Clinical Types of Goitre With Special Reference to the Adenomatous Type.
H. J. Vandenburg, Grand Rapids.

The adenomatous type of goitre is treacherous because of its tendency to attack the myocardium. There is no guarantee that a given case will not do so at any time. Therefore, it would be good practice to advise removal of all adenomatous goiters.

Demonstration of cases.

3. Resume and General Consideration of Osteomyelitis of Hemotogenous Origin.
Leon M. Bogart, Flint.

(a) Osteomyelitis of Hemotogenous Origin is more frequently met with now, or more easily diagnosed due to a greater precision of methods of diagnosis.
(b) Acute Osteomyelitis is essentially a disease of the young and adolescent.
(c) The disease is usually metastatic from a distant focus of infection and is carried by the blood stream.
(d) The infection may spread by continuity as well.
(e) The important symptoms, being excruciating pain in the bone at the seat of infection, high temperature and oedema. X-ray findings may be negative in acute cases though most important in sub-acute and chronic cases.
(f) Early recognition is essential to successfully cope with the disease.
(g) Treatment in acute cases should be early evacuation and drainage and in chronic and sub-acute cases wait for the sequestrum to form and then remove the same with proper considerations for future bone regeneration.
(h) Distant foci of infection must be dealt with in attempting a permanent cure of this disease.

THIRD SESSION

1:15 P. M.

1. Election of Chairman.
2. To be announced. (By invitation.)
Willard Bartlett, St. Louis, Mo.
3. Some X-Ray Studies in Bone Pathology.
P. M. Hickey, Ann Arbor.

(a) Illustrative cases showing the effect of muscle pull in fractures.
(b) Changes in the architecture of bone due to stress.
(c) The influence of function on the development of the skeleton. (Illustrated by lantern slides.)

4. Indications for and Limitations of the Various Bone Splints in the Treatment of Mal- and Un-united Fractures.
W. J. Cassidy, Detroit.
5. Traumatic Neurosis in Its Relation to the Surgeon.
Fred P. Currier, M. D., Grand Rapids.
R. H. Denham, M. D., Grand Rapids.

Outline:

(a) The disease defined and reasons for discussing this subject before the surgical section.
(b) Discussion from economic standpoint including Michigan Compensation Laws.
(c) Brief review of important literature on the subject up to date.
(d) Summary of our experience with this disease with special reference to etiology.
(e) Conclusion.

GYNECOLOGY AND OBSTETRICS

Chairman—Ward F. Seeley, Detroit.
Secretary—R. Cron, Ann Arbor.

September 12, 1:15 P. M.

1. "Endocervicitis."
A. E. Catherwood, M. D., Detroit.

Pathology gross and microscopic, symptoms and treatment, operative and non-operative with lantern slides.

2. "Diseases of the Cervix Uteri and Their Treatment."
Howard H. Cummings, M. D., Ann Arbor.

(a) The consideration of cervical lacerations with the resulting ectropion and erosion. The simple method of preventing these conditions which may be applied in office practice.
(b) Chronic infections of the cervical glands in nulliparous women, or in women who have borne children. The method of curing a persistent and irritating leucorrheal discharge. Value of

the Sturmford's operation in preference to amputation of the cervix.
(c) Acute and chronic gonorrheal endocervicitis and its treatment.

3. "Anterior Poliomyelitis Complicating Pregnancy With Report of Two Cases."
Norman F. Miller, M .D., Ann Arbor.

This condition complicating pregnancy is by no means common. An abundance of literature exists on enterior poliomyelitis but curiously enough very little is to be found regarding the condition as a complication of pregnancy and labor.
Two cases are reported. In one pregnancy was interrupted at the sixth month. In the second case delivery of a normally developed child took place at term.
The prognosis for a normal delivery; for a normal child; and for ultimate recovery are yet to be determined. The number of cases observed and reported are too few to permit worth-while conclusions.

4. "Goitre in Pregnancy."
C. E. Boys, M. D., Kalamazoo.

The effects of goitre on pregnancy; the effects of pregnancy on goitre; the medical treatment and the operability of goitres during pregnancy. Report of personal cases.

SECOND SESSION

September 13, 9:00 A. M.

1. "Pathological Uterine Activity as a Cause of Dystocia."
Theodore W. Adams, M. D., Ann Arbor.

A paper dealing with the various types of dystocia arising from abnormal uterine contractions. Hyperuterine activity: its causes, results, and the treatment of its various manifestations. The etiology of primary and secondary inertia with a general consideration or the differential diagnosis and treatment of these two conditions.

2. "Dystocia Due to Abnormalities of the Soft Parts of the Generative Tract." Illustrated with Lantern Slides.
Walter Manton, M. D., Detroit.

Conditions found in soft parts resulting in difficult labor may be classified in three groups.
(a) Congenital anomalies.
(b) New growths, benign and malignant.
(c) Acquiring deformities, due to surgical operation or specific trauma, or to infection. Treatment is instituted according to whether these conditions exist in the upper part of the birth canal or in the lower part.

3. "The Practical Aspects of Contracted Pelvis."
E. D. Plass, M. D., Detroit.

The ordinary methods of pelvic measurement suffice merely to indicate the small group of women in whom the possibility of pelvic dystocia should be considered; while the actual determination of the degree of disproportion must be determined by other means. The ideal treatment for contracted pelvis is abdominal Cesarean Section in cases with serious disproportion, with a prospect for a spontaneous outcome in other cases. A well developed obstetrical judgment is necessary if Cesarean Section is not to be abused, and if, on the other hand, difficult vaginal delivery is not to be required.
Lantern slide demonstration.

4. "Dystocia From Fetal Causes."
George Kamperman, M. D., Detroit.

Fetal dystocia will be considered with the following classifications in mind:
I. Dystocia due to abnormally large fetus.
II. Dystocia due to fetal malformation.
III. Dystocia due to difficult presentations and positions.
(a) Posterior positions.
(b) Face and brow presentation.
(c) Transverse presentation.
(d) Breech presentation.

Discussion on these papers to be opened by Dr. A. W. Fralick, Maple City, Mich., and Dr. Milton A. Darling, Detroit, Mich.

THIRD SESSION

September 13, 1:15 P. M.

Election of Chairman.
Election of Secretary for two years.

1. "Tube Inflation in Its Relation to Sterility Problem."
Harold Henderson, M. D.
T. G. Amos, M. D., Detroit.

(a) Development of the procedure.
(b) Scope of usefulness, dangers and limitations of its usefulness. Types of cases upon which it may be used with safety.
(c) Technique. Description of the syringe method.
(d) Interpretation of findings. The value of the stethoscope in this work.
(e) Case reports.

2. "Cancer of the Breast."
R. R. Smith, M. D., Grand Rapids.

(a) Discussion of statistics as to cures by various methods.
(b) Use of radium and x-ray without operation.
(c) The use of x-ray following operation.
(d) Operability and its determination.
(e) Program for the handling of all tumors of the breast.
(f) The operation.
(g) What incision is best?
(h) What should be removed and how?
(i) What about after care and the use of the arm?
(j) How should the patient be followed up afterwards?

3. "Diagnostic Value of X-Ray in Obstetrics."
A. M. Campbell, M. D., Grand Rapids.

Roetgenography as a diagnostic aid in obstetrics has been attempted for over a quarter of a century. Early progress was limited because of inadequate apparatus and imperfect technique. Important recent advances have been made which should encourage more general use of this agent. Personal case reports demonstrating its value. Lantern slide demonstration.

4. "Deep X-Ray Therapy in Malignancies of Cervix and Uterus."
Clyde K. Hasley, M. D., Ann Arbor.

Preliminary report.

SECTION ON OPHTHALMOLOGY AND OTO-LARYNGOLOGY

Chairman — Howard W. Pierce, M. D. Detroit.
Secretary—Benton N. Colver, M. D. Battle Creek.

FIRST SESSION

September 11, 9 A. M. to 12 M.

Operating Clinics:

Blodgett Hospital.
Butterworth Hospital.
St. Mary's Hospital.

The Grand Rapids men will provide interesting Eye, Ear, Nose and Throat clinics for this session. The list of operations will be posted early Tuesday morning at the Registration Bureau and at the offices of the three hospitals.

SECOND SESSION

September 11, 2 P.M. to 5 P. M.

Post-Graduate Lectures.

2:00 to 2:40—Clifton F. McClintic, M.A., M.D. Director of the Department of Anatomy, Detroit College of Medicine and Surgery and Associate in Neurology, Providence Hospital, Detroit.

"The Practical Significance of the Function and

Anatomy of the Base of the Cranium and Cranial Nerves in the Practice of Ophthalmology, Otology and Rhinology."

A knowledge of the physiology and anatomy of the structures at the cranial base including the cranial nerves and their connections enables the Opthalmologist, Otologist and Rhinologist to (1) anticipate secondary infections and determine what avenues they may follow. (2) a knowledge of the function of the parts involved along the routes of infection enables one to localize the seat of infection from the presenting signs and symptoms and forms (3) a basis upon which a rational and scientific plan of surgical or therapeutic procedure can be determined with a fair basis upon which to make a prognosis.

The paper will deal with the avenues mentioned along which secondary infections travel, the function of the parts involved will be discussed and the symptoms resulting therefrom will be accounted for. The structures encountered in operative procedures will be discussed together with the vestibular and cochlear apparatus with the reasons for the various tests used in diagnosis. The parts discussed will be illustrated by wet specimens dissected to show the relationships.

2:45-3:25—"Clinical Ptthology of the Tonsil."
James E. Davis, M. D., Detroit.

3:30-4:10—

4:20-5:00—

(Note)—The other two lecturers have not been definitely arranged for at this date (July 13). It is expected that they will be two men from out of the state, and that the subjects will be of general interest.

THIRD SESSION

September 12, 1:15 P. M. to 4:00 P. M.

Round Table Discussion.

Every Registrant in the Section is urged to present at this discussion any interesting observation or personal conclusion of practical importance to the rest of the men. It is believed that such an experience meeting will develop intense interest and be of great value to all.

FOURTH SESSION

September 13, 9 A. M. to 11:30 A. M.

Dry Clinic.

Under the direction of Dr. Roy T. Urquhart from twelve to fifteen selected cases will be presented by various men, giving the clinical history, the examination findings, the medical or surgical care, and indicating complications and end results, with the presentation of the patient. Similar clinics have been remarkably successful in other states.

FIFTH SESSION

September 13, 1:15 P. M. to 4:00 P. M.

Election of Chairman.
Scientific Session.

1. "Plastic Surgery of the Eye." (Lantern slide demonstrations).
Walter R. Parker, M. D., Detroit.
2. "Is There Any Reason to Assume That Insolation May Be an Etiological or an Assisting Etiological Factor in Producing a Form of Nystagmus Which Somewhat Resembles the Nystagmus in Multiple Sclerosis""
Emil Amberg, M. D., Detroit.
3. "Changes in the Lungs and Bronchi Due to Affections of the Upper Respiratory Tract."
J. S. Pritchard, M. D., Battle Creek.
Discussant: Preston M. Hickey, Ann Arbor.
4. "A Method of Holding the Septal Membranes in Apposition After a Submucous Resection Without the Use of Packing. Description and Demonstration of the Instruments for Performing It and the Method of Use, Illustrated by Lantern Slides."
H. Lee Simpson, M. D., Detroit.

Important points favoring the use of such method: marked lessening post operative bleeding, reduction of post operative discomfort to practically none. A plea for doing away with post operative packing after all intra-nasal operations in nearly all cases.

5. (a) "Relation of Diseases of the Eye to Nasal Disturbances." (Lantern Slide Demonstrations.)
Edward J. Bernstein, M. D., Detroit.

That many eye troubles owe their origin to extra ocular sources long known.

Many cases asthenopia, even properly refracted, only yield when pressure on middle turbinates is corrected.

Sluder's lower half headache, due to irritation of the sphenopalatine ganglion.

Empyema of sinuses responsible for most extrenal eye diseases and many cases of keratitis, iritis, choroiditis, retinitis—to thrombosis of lateral sinuses.

(b) "Intra-Ocular and Retro-Bulbar Neuritis, Due to Hyper-Plastic Ethmo-Sphenoiditis. Report of Cases. Lantern Slide Demonstration of Author's Original Investigation of the Sinuses in Their Relation to the Optic Nerve."
J. M. Southerland, M. D., Detroit.

PEDIATRICS

Chairman—T. B. Cooley, Detroit.
Secretary—Lafon Jones, Flint.

Wednesday, September 12, P. M.

1. Ventricular Pneumography in Infants and Children. Dr. M. Boyd Kay, Detroit.
2. Acrodynia.
Dr. Stanley D. Giffen, Toledo, Ohio.
3. Studies in Secondary Anemia.
Dr. J. C. Montgomery, Detroit.
4. Menstruation and Its Disorders in Early Adolescence.
Dr. G. M. Brown, Bay City.

Thursday, September 13, A. M.

1. [illegible] Dr. W. C. C. Cole, Detroit.
2. Title to be announced.
Dr. D. Murray Cowie, Ann Arbor.
3. Treatment of Acute Vomiting in Infants and Children.
Dr. David J. Levy, Detroit.
4. Vitamins and the Baby.
Dr. Joseph Brenneman, Chicago.

Thursday, September 13, P. M.

Election of Chairman and Secretary.
1. Title to be announced.
Dr. W. S. O'Donnell, Ann Arbor.
2. Title to be announced.
Dr. Julius Hess, Chicago.
3. Title to be announced.
Dr. John Paul Parsons, Ann Arbor.

SECTION ON PUBLIC HEALTH

Chairman— Guy L. Keifer, Detroit.
Secretary—W. J. Deacon, Lansing.

September 13

9:00 A. M.—Chairman's Address.
Dr. Guy L. Keifer, Detroit.
Endemic Goitre as a Public Health Problem.
Dr. C. C. Slemons, H. O., Grand Rapids.

Discussion by Dr. C. A. Neafie, H. O., Pontiac.
Dr. C. P. Drury, H. O., Marquette.

W. C. Hirn, Assistant Sanitary Engineer, Michigan Department of Health.

The Local Control of Epidemics.

Dr. Thos. B. Marsden, Epidemiologist, Michigan Department of Health.

Discussion by Dr. Burt U. Estabrook, Deputy Commissioner Detroit Department of Health.

Dr. Wm. De Klein, H. O., Saginaw.

Dr. Robert Stevenson, H. O., Flint.

11:00 A. M.—Business Meeting.

2:00 P. M.—Recent Advances in Public Health Laboratory Methods.

Dr. H. W. Emerson, Hygienic Laboratory, University of Michigan.

Discussion by Dr. R. W. Pryor, Director of Laboratories, Detroit Department of Health.

The Field Training of County Nurses.

Miss Lois Barrington, Supervisor of Wayne County Nurses.

Discussion by Dr. F. R. Town, H. O., Jackson.

The Relation of Street Dust to Public Health.

Prof. W. C. Hoad, University of Michigan.

Discussion by W. A. Sperry, Director of Public Health, Grand Rapids.

Dr. A. Wehenkle, Director Tuberculosis Division, Detroit Department of Health.

COUNTY SECRETARIES' LUNCHEON

Every County Secretary is invited and urged to attend the luncheon at the Pantlind Hotel at 12:15 M., as the guests of the Council.

This is a gettogether meeting and every County Secretary is expected to be present. Please send in your acceptance and intention to be present to the State Secretary. The Council looks forward to your attendance.

ENTERTAINMENT

The entertainment features of this meeting will be under the supervision of Dr. A. M. Campbell. The formal features will be:

Sept. 11, 9:00 P. M.—Social Session and Smoker at the Peninsular Club.

Sept. 12, 8:30 P. M.—Kent Country Club. President's Reception, Artists' Entertainment and Dance.

LADIES' ENTERTAINMENT

Entertainment for the visiting ladies will be provided for on Wednesday afternoon and on Thursday. Detailed announcement will be made at the time of registration.

What's in a Name?—At the Detroit Examinations (June 11-13, 1923), held by the Michigan State Board of Registration in Medicine, the applicants represented regular medical students and graduates, drugless practitioners (chiropractors) and chiropodists. During the examination in bacteriology, one of the chiropractors asked the examiner if he had not been given through error the questions meant for the chiropodists. The examiner answered "No." "What makes you think so?" He replied, "Look at the first question in this paper." The question was "Distinguish between ptomains leucomains."

Book Reviews

RECOVERY RECORD FOR USE IN TUBERCULOSIS. Webb and Ryder. Price $2.00. Paul B. Hoeber, Publisher, New York City.

This is a most splendid and sensible record. Send for one and then see that each one of your tubercular patients obtains one. It will aid you and them in bringing about a recovery.

INTERNATIONAL CLINICS. Volume 2. Series 23. J. B. Lippincott Co., Philadelphia.

Up to it's usual standard. But of especial interest because of a most complete discussion of Insulin. The subject of Diabetes and Insulin is exceptionally well covered and is worth the price of the volume alone.

THE MEDICAL CLINICS OF NORTH AMERICA. May, 1923. W. B. Saunders Co., Philadelphia.

The May number is the San Francisco number. The standard is maintained. The articles are of sufficient diversified interest to attract and instruct the physician and surgeon alike.

THE INFANT AND YOUNG CHILD. Its care and feeding from birth until school age. A manual for mothers. By John Lovett Morse, M. D., Edwin T. Medical School and Children's Hospital, Boston. 12mo of 271 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1923. Cloth, $1.75 net. Wyman, M.D., and Louis Webb Hill, M.D., of Harvard

A splendid text for mother because it enables her to obtain the knowledge that it is so requisite for her to have for the better care of her infant and child.

1922 COLLECTED PAPERS OF THE MAYO CLINIC, Rochester, Minn., Octavo of 1394 pages, 488 illustrations. Philadelphia and London: W. B. Saunders Company, 1923. Cloth, $13.00 net.

These collected papers impart authoritative discussion, comment and opinion upon outstanding medical and surgical problems. Conditions which confront every doctor and upon which he is seeking further information. Hence the value of this collection. It is up to its established standard in value, instruction and interest. It is a distinct contribution to our literature. It should be read and studied by every conscientious physician.

BUTTERWORTH HOSPITAL STAFF

The following appointments were made by the Board of Trustees of Butterworth Hospital, Grand Rapids, June 4, 1923: Doctors R. J. Hutchinson, Chief of Staff; G. L. McBride, Vice-Chief of Staff; R. F. Webb, Chief of Surgery; A. B. Smith, Vice-Chief of Surgery; B. R. Corbus, Chief of Medicine; A. J. Baker, Vice-Chief of Medicine; J. R. Rogers, Chief of Eye, Ear, Nose and Throat; H. S. Collisi, Chief of Obstetrics; F. J. Larned, Chief of Pediatrics; and F. C. Warnshuis, Supervisor of Out-Patient Department. In addition to the above, 50 other physicians were appointed to the various departments. Among these 50 are Doctors W. J. DuBois, R. H. Spencer, A. V. Wenger, J. D. Brook and J. S. Brotherhood. Doctors W. E. Blodgett of Detroit, Henry Hulst, George F. Inch of Kalamazoo, C. H. Johnston of Grand Rapids, Perry Schurtz, of Grand Rapids, and D. Emmet Welsh of Grand Rapids were appointed to the Consulting Staff. Dr. Eugene Boise of Grand Rapids and Dr. L. A. Roller of Grand Rapids were appointed Honorary Staff Members.

The Journal
OF THE
Michigan State Medical Society
ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

J. B. Jackson, Chairman.....Kalamazoo
R. C. Stone.....Battle Creek
J. McLurg.....Bay City
R. S. Buckland.....Baraga

Editor and Business Manager
FREDERICK C. WARNSHUIS, M. D., D. Sc., F. A. C. S.
Grand Rapids, Mich.
GUY L. CONNOR, M. D., F. A. C. P.
Associate Editor, Detroit.

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The Society does not hold itself responsible for opinions expressed in original papers, discussions, communications, or advertisements.

Subscription Price—$5 per year, in advance

AUGUST, 1923

Report Malpractice Threats Immediately to Doctor F. B. Tibbals, 1212 Kresge Bldg., Detroit, Mich.

Editorials

OUR ANNUAL MEETING

This issue contains the program and announcements for the annual meeting that is to be held in Grand Rapids on September 11, 12 and 13th. While some of the minor details of the program are not imparted in this issue, that which is printed will characterize our annual session. We are of the opinion that it is going to be an attractve and profitable meeting. We trust that a goodly number of our members will plan to attend. We urge that you plan now to attend this meeting and participate in its deliberations.

Every county society is entitled to one delegate for every fifty or major fraction of fifty members. The house of delegates is the legislative body of our society. Every county society should be represented in our house of delegates. County societies are urged to select as delegates men who will not only attend, but who will represent them by participating in the discussions and activities of that representative forum of our society. To be a delegate is not an idle honor. It carries definite responsibilities and as delegates meet up to those responsibilities, so will our society meet up with its responsibilities to its members and to the public. Delegates are urged to be present at the first session of the house and to assume the duties that have been reposed in them.

The profession of Grand Rapids, as members of the Kent County Medical Society, have been actively at work, through designated committees, in preparing for your coming and for your comfort and entertainment. You will find them to be most hospitable entertainers and solicitous hosts. In addition to the announced entertainment features, three golf courses are open to those who desire to play golf. Especial effort will be made to provide entertainment for the visiting ladies.

The scientific features of the program reveal that section officers have planned a most interesting series of scientific discussions that are most timely. No member can afford to miss hearing these papers and discussions. Ample provision has been made for comfortable meeting places for all sections.

It is not necessary to dwell further upon what this annual meeting will provide, or, the benefits that will accrue to each member who attends. Grand Rapids physicians bid you come and welcome.

SAN FRANCISCO A. M. A. MEETING

Inasmuch as our delegates will submit a complete report next month at our annual meeting we do not purpose to make extended comment in this issue upon the annual meeting of the American Medical Association that was held in San Francisco the week of June 25th.

It was a splendid meeting, held in a city that is an ideal convention city on account of its climate and civic auditorium, which was able to house all the meetings under one roof. Though distant from the country's center of population, some 5,000 fellows registered. Michigan was represented at all the sessions of the house of delegates by Doctors Hornbogen, Brook, Frothingham and Taylor. A goodly number of Michigan doctors were present.

As to official action taken, our delegates will discuss this feature of the deliberations. Dr. Ray Lyman Wilbur of Leland Stanford University is president for the current year. Dr. Pusey of Chicago was chosen as president-elect. Dr. Olin West was elected secretary to succeed Dr. A. R. Craig, deceased . Dr. Wendal Philips of New York, is chairman of the board of trustees. Your Secretary-Editor was re-elected as speaker of the house of delegates. Chicago was selected as the place for our 1924 meeting.

WHAT THE A. M. A. IS DOING

The query is frequently made as to what the American Medical Association is doing and why a doctor should support this national organization. To answer this query in part, we are publishing some of the reports that were rendered at the San Francisco meeting this year. They impart very clearly the work that is being accomplished. We ask that our members read, with careful thought, every one of these reports. If you will do so you will receive a new insight as to what a wonderful and important work our national association is performing. Likewise, you will glean why you personally should subscribe support by becoming a Fellow of the A. M. A.

THE AMERICAN MEDICAL ASSOCIATION

Several interesting facts were presented in Secretary West's annual report. They are so germaine to our State Society that we are quoting them for the information of our members and for their reflection.

The American Medical Association on May 1st had a membership of 88,519, who were affiliated through 2,049 component societies. Of that number 53,444 were Fellows of the association.

Here we desire to again explain the differentiation between fellows and members. In our plan of organization a physician joining a County Society automatically becomes a MEMBER of his State Society and a MEMBER of the American Medical Association. He pays NO DUES to the American Medical Association.

To become a FELLOW he must make application to the national body, must subscribe to the Journal of the A. M. A. and MUST PAY fellowship dues. These annual dues, which INCLUDE subscription to the Journal, are $6.00 per year. Many of our members think they are Fellows, when, as a matter of fact, they are not, because they have not made application and have not paid the annual dues. Only Fellows are eligible to participate in the annual meeting of our national association.

Our State Society has 3,147 members, of which number 1,693 are Fellows of the American Medical Association. This is not as it should be. Michigan owes greater numerical support to our national organization. Not less than 2,750 of our members should be Fellows of the A. M. A. Why?

Because: They should support our national organization in the work it is doing for them, and by reason of which they profit, in medical legislation, council on pharmacy and chemistry, medical education, hospital interne standardization, public health education, state licensure, research, cumulative index, national legisaltion, propaganda department, and The Journal of the American Medical Association, which is the greatest medical publication in the world. By reason of these and other activities that are being engaged in, you, doctor, profit and benefit and it is but fair that you should support those who are thus working for the enhancement of your welfare. We urge that if you are not a Fellow, that you today make application. Do it now.

We quote the following from Secretary West's report:

Medical organization exists for the purposes of (1) creating for its members opportunities for their scientific improvement, and (2) promoting the general welfare of the medical profession. The beneficent service of the profession can be rendered to best advantage only as its members are kept abreast of advances in medical science; the truths and proved methods of scientific medicine can be applied by its practitioners to the best advantage only when their economic status is such that they will be able to devote themselves as wholly as may be to their professional duties.

The achievements and successes of medicine and medical organization have been based on the fact that scientific advancement and helpful service to humanity have been the great fundamental considerations always held in the view of worthy physicians. It is on this basis, too, that the destiny of medicine and medical organization will be worthily fulfilled. It is nevertheless true that the organization which takes no thought for the material interests of its members fails in a most important duty to them and to the public they serve. In striving for economic improvement, we must never lose sight of the fact that the interests of the patient and of the public are paramount.

That the American Medical Association has wrought powerfully for the promotion of medical science and for the enrichment of the scientific knowledge of its members, none will deny. There are those who affirm that it has not labored efficiently for the improvement of the economic status of the medical profession. The fact is that a great deal of thought and effort have been expended by the general officers and the entire administrative personnel of the Association for making it serve to the greatest possible extent the promotion of the general professional welfare.

Within the last year or so innovations have been made, some of which are succeeding splendidly while some are not yet operating as intended because of conditions which, in time, will be removed. The Bureau of Legal and Legislative Medicine, as will be seen from the report submitted to this house, has been busy with many important matters and has achieved some notable successes, even though the bureau is only one year old.

The publication of Hygeia has been undertaken with the purpose of giving authentic information to the public for its benefit and to bring about an understanding of the aims, methods and purposes of the medical profession that will result in securing increased respect and esteem for it from the general public.

The creation of a field secretaryship was an effort to increase organizational efficiency. The work of this department was temporarily suspended because

conditions arose that were beyond control and made suspension necessary. It is proposed to resume this work at the earliest possible time.

With a view of establishing closer contact between component and constituent societies and the Association, its president, members of the Board of Trustees, the Secretary, the Field Secretary and several of the department heads have attended meetings of state, district and county medical societies and of councils of state associations during the past year. At these meetings, when opportunity offered, the work of the Association was presented and suggestions were sought as to how it might be made more helpful to medical societies and their members . On specific requests, representatives of the Association have appeared before medical societies whenever possible to discuss organizational problems and methods and to secure information that might be used to good advantage for increasing and extending the service of the parent organization to its component and constituent units. It is proposed to make further development along these lines and to provide speakers to address themselves to subjects of general professional interest, but more particularly to those bearing on medical organization and medical economics. Of course, it cannot be undertaken to provide contributions to scientific programs at society meetings.

Some constituent associations, notably those of Wisconsin, Pennsylvania and North Carolina have, in co-operation with universities, initiated postgraduate courses of study for members of county medical societies. Some sectional societies, notably the Pacific Northwest Medical Association and the Tri-State District Medical Society, all of whose members are required to be members of this Association, have developed splendid programs with diagnostic clinics as an outstanding feature. It may be feasible, at some time in the not distant future, for the American Medical Association to undertake activities of this nature. The matter is now being considered in the hope that a plan can be worked out whereby teachers and demonstrators for postgraduate lectures and diagnostic clinics can be provided for cooperating county or district societies. It is respectfully recommended that this house authorize the proper officers of the Association to organize such a plan and put it into effect.

The American Medical Asosciation, with its nearly 90,000 members, is made up of more than 50 separate and largely independent organizations, each within its own peculiar problems and its own determining influences. In such a body it is oftentimes difficult, if not impossible, to determine where the weight of opinion lies with respect to any debatable question of procedure. It sometimes happens that when those upon whom administrative responsibility has been placed act to discharge what they conceive to be their duty in given premises, they receive as much of condemnation as of commendation. One large group insists that an attitude of most aggressive opposition should be assumed toward all or toward certain cults and their programs, legislative and otherwise. Another group, just as large and altogether as representative, takes exactly the opposite position. One state association may demand what another definitely objects to.

Our scheme of medical organization is, theoretically, extremely democratic. In its practical application it is evidently the desire of the members and of the officers of this Association that it shall operate along democratic lines to the fullest extent compatible with effective methods and with the possibilities for real accomplishment. It would seem, therefore, that the constituent state association should assume initiative in most organizational affairs and in most movements of interest to the medical profession. There appears to be, however, a very decided difference of opinion as to where the initiative of the American Medical Association should begin and where the responsibility of the constituent state association leaves off. There are those things which the state association must do for itself, which the American Medical Association cannot do for it and should not do if it could. There are those things which the state association can do for itself or which the American Medical Association can do for it. In such matters it would seem wise for the state association to take the initiative and for the parent body to act only on the request of the constituent organizaion. There are still other things that the American Medical Association can do for its constituent and component societies and their members which they cannot do as independent organizations. These the Association should do on its own initiative and to the limit of its facilities. The publication of seven scientific journals and a magazine for the lay public, all of which have won recognition as meritorious periodicals, is evidence that the Association has not been unmindful of its duties and responsibilities. The headquarters organization is a veritable service bureau, in which all departments co-operate in replying to thousands of inquiries of every conceivable kind each year. Numerous other examples of service rendered by the Association in an effort to discharge the responsibilities which devolve directly on it might easily be cited. That so much has been done is an earnest that more will be undertaken, when, as a result of constructive criticism, supplemented with constructive suggestions, methods can be devised and means provided. It is for this house of delegates, composed of the chosen representatives of the nearly 90,000 physicians who make up its membership, to determine and define the policies of the Association with respect to its relations with component and constituent societies, its relations with other organizations, and its relations with the body politic.

We firmly believe that the doctors of Michigan owe whole-hearted support to the American Medical Association and should manifest that support and loyalty by becoming fellows. Again we urge—Do it now.

Editorial Comments

The Grand Rapids profession is expecting you to come and be their guests during the state meeting, September 11-12 and 13th. You should plan to attend this meeting.

We direct our readers' attention to the very interesting Report of the Public Health Committee of Wayne county. This will be found under County Society news. It reveals a splendid activity on the part of Wayne county.

As a member of your county and state society you are a member of the American Medical Association. You are NOT a fellow of the A. M. A. To become a fellow you must make application and pay annual dues. As a doctor, as a member of your county and state society, you should become a fellow of the A. M. A. Send in your application now.

Yes, we are devoting considerable space to reports on work being done by the American Medical Association. We feel that our members should become more familiar with the activities of our na-

tional organization. This national body is active in your behalf and merits your whole-hearted support. We sincerely urge that you read them.

There will be ample accommodations for our annual meeting in Grand Rapids, September 11, 12 and 13th. General headquarters will be at the Pantlind hotel. In addition first class accommodations may be obtained at Hotel Rowe, Mehrtens, Crathmore hotel and the Livingston hotel. Though these accommodations are available, we urge that you write for reservations, for Grand Rapids always has a iarge transient business and many tourists. To be sure of satisfactory accommodations, make your reservations now.

The American Medical Association has, during the past three years, been very fortunate in having chosen representative, keen, clear thinking presidents who have contributed much to the good of our national organization. Dr. Lyman Wilbur, the present president, reveals his capability and merit in the following extract from his address to the house of delegates:

THE HOUSE OF DELEGATES

This Association is a very interesting and remarkable organization. In some ways, it reminds me of Topsy; it has just grown up in a certain direction. It is an attempt in a great republic to get a form of representative government for the physicians of the country. It has various methods of doing its work. I will admit that it needs certain changes and certain revisions. This house of delegates should be, as it is, a great policy-making body. I think sometimes it acts as an administrative body. No legislative body can do efficient work without an effective organization.

THE BOARD OF TRUSTEES

I have gone to the meetings of the board of trustees. They are a splendid group of men. It has been my fortune and misfortune sometimes to deal with a number of boards and trustees of all sorts, and I can say quite frankly that the board of Trustees of the American Medical Association is just as good as any board of trustees in the country, but it is largely a custodial body. It does the custodial side of its work admirably.

A BOARD OF STRATEGY

What this organization needs is the thing Dr. Simmons has given it as an individual because of his peculiar position, and that is a board of strategy. It needs an administration that looks five or ten years ahead. We are plunging right along as a great medical body into all sorts of problems and difficulties. The board of trustees is meeting many of these problems.

There has been a discussion of having a member in the president's cabinet of public welfare. You cannot run a university unless there is some one who is thinking five or ten years ahead. That is my position as president of a university. I am supposed to be looking ahead all the time. You must get a board or some one of that type for this organization.

Scientific medicine is moving ahead so rapidly that in many ways we have left the people far behind and also some members of our own profession. We are mixed up in every one of the 41 different states with legislatures and boards of health. The Speaker has referred to the need of getting our policies in such condition as to stand together, and in doing that we should realize, as a national organization, that we have to expect each state organization to work out its own policy.

DECENTRALIZATION

In the war, Washington became too prominent in this country's affairs. Every governor and every legislature looked to Washington during that time. That is a weakness. We must get decentralization of organization to force responsibility on the state organization, so that it will take the initiative in meeting its local conditions. It is a great problem in organization to get men at headquarters so that there is good management and wise provision for the future, so that each state may get the benefit of all information that comes in at headquarters, and that each state, as far as possible, be left to work out its own problems, and in its own way. This can be done. If you should make the present board of trustees such a board of strategy as I have outlined, they can carry this movement forward.

Some group of men must be thinking of what is going to happen to medicine in this country five, fifteen or twenty years from now.

What are the conditions under which medical students will be practicing fifteen or twenty years from now, and what is the Association to lay down as a groundwork so that the profession can go on with increasing opportunities, increasing responsibility and increasing service? It is a great task. It requires a great deal of thought, but it can be done.

One of the greatest functions of this Association has been the education of the medical profession through meetings like this, through publications such as The Journal. I wonder how many of you realize the enormous influence The Journal has exerted on medical education. Every physician has to learn something daily or he is going backward.

THE JOURNAL

The Journal of the American Medical Association, under the leadership of its editor and general manager, has been a source of inspiration and direction for the members of the profession. Every man in the profession has had not only to get scientific training through The Journal, but also a certain amount of technical training, and has had the opportunity to become informed as to what is going on in medical education and legislation, and the job has been so well done that we have accepted it. It is going to be a great task to work out the different problems in the years to come, and it will require great thought on your part if we are going to do as much for the profession in the future as we have done in the past. Think for a moment of the problem of the man who is on what we might call the borderline of medical practice, serving the public somewhat more than he is any individual patient. Think of the attitude of the public toward him, and realize that this is the element that is growing in medical practice. There is less service to the individual by the profession and more service to the public, and the public is being served through the individual more than ever before, and it requires many points of view to bring about a satisfactory division of pubilc relationships under these conditions. It can be done, but it cannot be done unless we are willing to think it out thoroughly and unless we are looking ahead.

THE SCIENTIFIC SECTIONS

The most striking thing about this organization to me is the scientific sections. If you will study the organizations of these sections and look over the types of papers that are read, you can see great prospects in the development of American medicine. The real strength of the organization lies in its sections, and they are vital forces to the organization.

If there is anything in this whole scheme, it should be one of harmony of all the policies that go to

make up medical progress viewed in its broadest sense. Such an organization as this, while it must devote major thought to the major part, must never forget the others. We must look out for the general practitioners; but if we should look out for them alone, we would lose one of the great functions of this organization, which is to get the best thoughts of those in medicine, and bring them within our door. That has been done up to date.

PERIODIC PHYSICAL EXAMINATION

There are a number of other points I have been requested to bring to your attention, two in particular. One is the increasing interest throughout the country for some form of periodic physical examination. This, if carried out, will afford the greatest possible opportunity of scientific medicine. It is a sad thing when a man wants to know where he stands in the world, and comes for an examination and is not given a thorough examination, but is laughed at, and the doctor tells him, "you are all right"; "don't come for an examination unless you are mighty sick or have a temperature of 105." Physicians ought not to take such an attitude, although it is the attitude that modern medicine takes in regard to the normal man and serves to isolate him against the diseases of his body. The physician should study biologic reactions of the man and help him to meet the problems that come to him in the way of disease. The physician should have a record of how the man stands when he first sees him, and compare that record with his condition six months hence; then he has something to stand by. If we could get that carried out through intellectual groups we would do more good than all the cults and faddists. There is no doubt in my mind that this is one great weakness. We are trained to think in terms of disease, and we must now turn our attention to thinking in terms of being well; when we do, the people will rally to us in a new way.

REPORT OF THE BOARD OF TRUSTEES

To the Members of the House of Delegates of the American Medical Association:

SUBSCRIPTION DEPARTMENT

In the tables in the addenda to the Trustees' report will be found the main facts regarding the circulation of The Journal covering last year—1922. Table 1 indicates that there were 4,204,844 copies of The Journal printed, and a weekly average of 80,862. Table 2 shows the number of physicians in the United States, the number receiving The Journal, and the approximate percentage in each state (the copies sent to the U. S. Army, the U. S. Navy, the Public Health Service and to advertisers, and the complimentary and exchange copies are not included). It will be noted that in 27 of the states more than 50 per cent of the physicians are receiving The Journal. Minnesota shows the highest percentage, 69; North Dakota the next highest, 67; California, Connecticut and Illinois, 65. Table 3 indicates the number of Fellows and subscribers each year from January 1, 1900, to January 1, 1923, and shows that with two exceptions there has been a steady annual increase in the number of Fellows, the exceptions being in 1911, a decrease of about 240; and in 1918, of about 700. There also has been a steady, consistent increase so far as subscribers are concerned, although the number of these is more likely to go up and down than the number of Fellows, for the reason that the Fellowship roll is continually being augmented by transfers from the subscription list. The vast majority of Fellows originally were subscribers, and were transferred to the Fellowship list; last year 2,898 were so transferred; in 1921, 3,329; and in 1920, 3,914.

For the first time in many years, there was an actual falling off in the bona fide circulation of The Journal. This occurred only once before, viz., in 1916, the second year of the World War. The decrease last year was only 112, and this could be explained by the fact that the government services decreased their order by 136. However, there has been quite a little falling off because of the $6 subscription price: many physicians have written that they understood the increase in price was to be only temporary, and that the $5 rate soon would be restored.

SPECIAL JOURNALS

A satisfactory report can be made regarding the five special journals now being published by the Association. The circulation of the Archives of Internal Medicine for 1922 was 2,526; of the American Journal of Diseases of Children, 2,841; of the Archives of Neurology and Psychiatry, 1,203; of the Archives of Dermatology and Syphilology, 1,316; and of the Archives of Surgery, 2,931.

In considering the circulation of these five journals, it is well to bear in mind that all are of special character and appeal not so much to the general practitioner as to the physician who is specializing in some particular line. For instance, we cannot expect that the Archives of Surgery will appeal to any but the more progressive surgeons. So also with the Archives of Internal Medicine: it is a medium for the publication of extended articles—articles representing advanced work and thus appealing only to the progressive internist. The American Journal of Diseases of Children appeals to the pediatrician, and to the progressive general practitioner, who is especially interested in this branch of medicine. The Archives of Neurology and Psychiatry and the Archives of Dermatology and Syphilology naturally have a limited circulation, since they appeal practically only to those who limit themseves to the specialties represented by these two journals.

Three of these journals—the Archives of Internal Medicine, the American Journal of Diseases of Children, and the Archives of Surgery were published at a profit; two—the Archives of Neurology and Psychiatry and the Archives of Dermatology and Syphilology—at a slight loss. There was a net gain on the special journals of $9,266.85, but only actual cost was charged against them; i. e., no overhead was included. It may be that your Board of Trustees will find it convenient to reduce the price of the American Journal of Diseases of Children and also of the Archives of Internal Medicine, unless there should be an increase in the cost of their production. On the contrary, it may be necessary to increase the price of the Archives of Neurology and Psychiatry and of the Archives of Dermatology and Syphilology. However, the board proposes to consider this question at its fall meting; at that time it will be possible to estimate the developments of the present year. It is unnecessary to say that the object of the Association is to supply these high-class scientific periodicals at only slightly above cost. The printing plant of the Association, its various facilities for procuring material, etc., make it possible to publish and to supply these special journals to subscribers at a less cost than they otherwise could be supplied.

AMERICAN MEDICAL DIRECTORY

The Eighth Edition of the American Medical Directory has been completed and will be in the hands of the subscribers before this session is held. Eight thousand five hundred copies have been printed. The number of prepublication subscriptions was practically the same as two years ago—

approximately 7,000; presumably the demand for the book after publication will be as great as that for the Seventh Edition. It is impossible to tell definitely what the actual income on an edition is until it is known how many copies are sold before the next edition appears. The financial report for the last edition shows that the expenses were $136,884.39; and the receipts from subscriptions, advertising, etc., $135,045.40; thus there was an apparent loss on the Seventh Edition of $1,838.99. However all the expenses connected with the Biographical Department was being conducted before the publication of a directory was given consideration; the work carried on in it is a continuing one, but inseparable from that connected with the Directory. But the work in this department and that on the Directory are so closely connected that it is impossible to separate the charges. Under all the circumstances, the Directory may now be regarded as self-supporting.

HYGEIA

An active campaign of promotion of Hygeia was begun among physicians in December and continued until about the middle of March. This promotion was in the form of advertisements in The Journal and through circulars. This campaign resulted in securing approximately 15,850 orders. About the middle of March, at the time the periodical appeared, a similar, active campaign was inaugurated among the public, appeals being made through circulars and personal letters to presidents of universities, state and county superintendents of schools, educational boards, women's clubs, teachers, etc. On the first of May, there were about 19,500 subscribers, the majority being those who had accepted the special offer. Since the first of May, orders have been continuing to come in at the rate of about twenty-five a day.

THE PROPAGANDA DEPARTMENT

The interest on the part of the public in The Journal's educational work on the nostrum evil, quackery and pseudo-medicine increases yearly. Especially does the public show an intelligent appreciation of the task which the American medical profession has assumed of warning the layman against the pitfalls of the nostrum vender, the cultist and the quack. More letters from laymen were received during the last year than in any previous year. The activity of various lay organizations (women's clubs, chambers of commerce, advertising associations, etc.) which have called on the Propaganda Department for information also reflect the interest of the public. Letters have come not only from every state and every dependency of the United States, but also from such widely separated places as Australia, China, New Zealand, the British Isles, France, Germany, and some South American countries.

Although there is a noticeable laxity in the advertising standards of many newspapers and magazines, there are an encouraging number of lay publications that honestly try to protect their readers against fraudulent medical advertising copy. As a result, the number of inquiries from men and concerns interested in truthful advertising has steadily increased. Then, too, a not inconsiderable portion of the correspondence of the department has been with teachers and students of schools and colleges. The fact that several standard textbooks on home economics, civic biology and related subjects deal at least incidentally with the nostrum evil explains this interest on the part of students and teachers.

The second volume of "Nostrums and Quackery," which has now been on the market for more than a year, is selling steadily. Since the issuance of "Nostrums and Quackery," the individual pamphlets on the nostrum evil have been brought down to date, re-edited and new editions published.

There is no question that the commercialization of the pseudoscientific vagaries of Albert Abrams of San Francisco is the most remarkable phenomenon of its kind since the days of the historic Perkins' Metallic Trators. Certain members of the medical profession were at first disposed to give Abrams and his theories serious consideration, but with the publication of various articles on these subjects in the Propaganda department of The Journal, Abrams' clientele shifted from that of the low-grade medical man to the osteopath. The unprecendented publicity given Abrams through sensational lay magazines, and the fact that the exploitation appeals alike to the faddist and to the mercenary, are responsible for the attention that has been given the subject. The material published in the Propaganda department of The Journal has been reprinted in pamphlet form with additions from other sources. Thousands of these reprints have been called for by the profession and the public, and the demand continues.

The first issue of Hygeia has brought to the Propaganda department additional inquiries on the subject with which the department deals, and there is every reason to believe that as Hygeia becomes better known the department will be called on more heavily than ever before, for the attention of the public will be drawn to the fact that in the Propaganda department the public and the profession have a clearing house for information on the nostrum evil and quackery, and that the data it furnishes are both reliable and authoritative.

COUNCIL ON PHARMACY AND CHEMISTRY AND THE CHEMICAL LABORATORY

During 1922, the Council and the Chemical Laboratory have continued their work in the interest of rational therapy. Each year finds an increasing number of physicians who are supporting this work, for the profession is realizing that the Council provides it with unbiased and dependable information concerning proprietary and new therapeutic agents.

The second volume of "Propaganda for Reform in Proprietary Medicine" was issed during the year, bringing the informative material up to date and making more available the important reports of the Council, the Laboratory and The Journal issued from 1917 to May, 1922.

The Council is devoting, and must continue to devote, a considerable part of its time to the routine examination of the new proprietaries that are brought out yearly. An increasing number of American firms are engaged in producing what promise to be worth-while additions to our materia medica. Even France, which in the past has been content with supplying for the most part ordinary drugs or drug mixtures under fancy titles or in fancy packages, is beginning to send to this country some of its products of importance.

The shotgun proprietary mixtures which handicapped scientific medicine fifteen ar twenty years ago now give little concern. Today the pressing problems are the "mixed" vaccines, the pluriglandular preparations, products especially elaborated for intravenous therapy, and the attempts to commercialize our new knowledge of vitamins. The Council continues to examine each "mixed" vaccine that is offered, but has accepted few of such mixtures. In spite of an extensive propaganda by certain firms which specialize in the manufacture of mixtures of endocrine substances, little, if any, scientific, controlled, clinical evidence has been presented to justify the almost ludicrous claims made by promoters.

During the year the Council has issued three reports bearing on vitamins: "Yeast Preparations," "Therapeutic Research into the Clinical Field of

Yeast," and "Yeast Preparations and Vitamin B Concentrates." These reports will, it is hoped, convince physicians that vitamin deficiency is best overcome by the selection of proper foods and not by the use of proprietary preparations claimed to be vitamin concentrates.

As the routine work of the Council is becoming systematized, more time is given by the members of the Council to broader questions concerning medical advance. At the present time, an appeal is being formulated against unnecessary intravenous medication, which, the Council believes, should be limited in application; its use in those cases in which there is no definite warrant for the procedure is still a serious menace both to medical science and to public welfare.

The changing tendencies of the times are best shown by the methods used to introduce new drugs. In years gone by, the favorite method of introducing a new drug was by supplying physicians with free samples. In return the promoter asked for—and frequently received—reports from the physicians as to the results they obtained from the use of these samples. The ability properly to weigh clinical and empiric evidence is not accorded to every observer; therefore, uncritical, laudatory reports were the rule, and these were promptly published. It required considerable time and controlled experimental work to produce accurate evidence to counteract such hastily published testimonials. Today, physicians look with a more critical eye on the evidence for new drugs, and the far-seeing manufacturer hesitates before investing money in a new drug that does not possess real merit. The Council has adopted a plan which, in time, should do much to prevent the flooding of the market with drugs that eventually will be found of little value. The plan includes the issuing of preliminary reports which enable the clinician to experiment with products of known composition that seem to have therapeutic promise.

The Chemical Laboratory continues to aid the Council in passing on new substances through an examination of the claims that are made for them regarding their chemical composition. It gives much time to the elaboration of standards for products that are admitted to New and Nonofficial Remedies, and thus insures that the products accepted for the book shall be uniformly reliable composition. The Laboratory answers many inquiries in regard to the composition of medicines which come to The Journal from its readers; and, when the requested information is not available and the subject of inquiry is of sufficient importance, it undertakes analysis of these products. The Laboratory is largely responsible for the fact that the secret nostrum exploited to the profession is waning. Furthermore, it endeavors to accomplish a certain amount of original investigation in fields of materia medica.

APPROPRIATIONS FOR RESEARCH

For many years the Board of Trustees has provided funds for the encouragement of research. This money is distributed through two committees: the Committee on Scientific Research and the Committee on Therapeutic Research. The grants are made to investigators of recognized ability and, in the main, provide funds only for the purchase of materials.

The committee on Scientific Research is composed of: Dr. Ludvig Hektoen (chairman), Chicago; Dr. F. F. Russell, Washington, D. C.; Dr. Herbert C. Moffit, San Francisco; Dr. G. N. Stewart, Cleveland, and Dr. Charles H. Frazier, Philadelphia. The object is to further meritorious research on subjects relating to scientific medicine and of practical interest to the medical profession, which otherwise could not be carried on to completion. During the year the following appropriations were made:

Grant 55: $200, to Reynold A. Spaeth, School of Hygiene and Public Health, Johns Hopkins University, for a study of the influence of fatigue on infection.

Grant 56: $200, to John F. Churchman, Loomis Laboratory, Cornell University, New York, for a study of the action of certain chemicals in the treatment of acute arthritis.

Grant 57: $250, to Yandell Henderson, Laboratory of Applied Physiology, Yale University for apparatus necessary for a study of the physiology of respiration.

Grant 58: $225, to E. B. Krumbhaar, Philadelphia General Hospital for a study of inguinal granuloma.

Grant 59: $225, to F. W. Mulsow, University of Iowa, for a practical study of culture mediums for the gonococcus.

Grant 60: $400, to H. M. Evans, Anatomical Laboratory, University of California, for the continuation of the study of the relation of endocrine glands to ovulation.

The Committee on Therapeutic Research is a committee of the Council on Pharmacy and Chemistry, and the funds appropriated for it are used to aid in investigating therapeutic questions. A special grant of $1,000 has been made to a committee appointed by the Committee on Therapeutic Research to investigate the toxicity and availability of local anesthetics. This work has been in hand for some time, and much valuable information regarding this important question is being secured. The committee is composed of: Dr. Emil Mayer, (chairman), New York (laryngology); Dr. Robert A. Hatcher, secretary, New York (pharmacology); Dr. Elliott C. Cutler, Boston (surgery); Dr. Henry S. Dunning, New York (stomatology); Dr. Robert S. Lamb, Washington, D. C. (ophthalmology); Dr. David I. Macht, Baltimore (medicine); Dr. Charles Norris, New York (pathology), and Dr. Alexander Randall, Philadelphia (urology). The committee has formulated a plan for carrying out an extensive investigation, and it is believed that the results will prove interesting and of practical value. To indicate the general character of the work carried on under the direction of the Committee on Therapeutic Research, we submit a list of the investigations conducted under the committee, the results of which were published during 1922:

The Effects of Some New Local Anesthetics: M. L. Bonar and Torald Sollmann: J. Pharmacol. & Exper. Therap. 18:467 (Jan.) 1922.

Uterine Effects of Intravenous Injections of Fluids: H. G. Barbour and F. H. Rapoport: J. Pharmacol. & Exper. Therap. 18:407 (Jan.) 1922.

Studies of Strychnin: Soma Weiss and R. A. Hatcher: J. Pharmacol. & Exper. Therap. 19:419 (July) 1922.

Seat of the Emetic Action of the Digitalis Bodies: R. A. Hatcher and Soma Weiss: Arch. Int. Med. 29:690 (May) 1922.

Action of Emetin Hydrochloride upon the Uterus: Paul Martin: Am. J. Obst. & Gynec. 3:241 (March) 1922.

Experimental Erysipelas: F. P. Gay: J. Infect. Dis. 31:101 (Aug.) 1922.

The Treatment of Syphilis by Mercury Inhalations: History, Methods and Results: H. N. Cole, A. J. Gericke and Torald Sollman: Arch. Dermat. & Syph. 5:18 (Jan.) 1922.

The Relative Therapeutic Efficiency of Arsphenamine and Gelatin Arsphenamine: Jean Oliver: Proc. Soc. Exper. Biol. & Med. 20:56, 1922.

BUILDING

The report of the Board of Trustees last year contained a brief historical outline of the Association property and building; referred to the fact that the previous year—1921—the Trustees considered it advisable, on account of the high cost of labor and material, to pospone the erection of the additions, and stated that by the time of their annual meeting in February prices had gone down sufficiently to make them feel justified in authorizing the completion of the plans. The general contract was signed, May 29, 1922, but the contract for the steel—the most important item among the material—was signed, June 31, at a price of $62.50 a ton erected. The next day (July 1) the price advanced, and in-

creased steadily until it reached $102 a ton. In view of the fact that it is requiring approximately 800 tons, this item is an important one. Other prices—of labor and of material—also went up almost immediately after our various contracts were signed.

Progress on the building has been extremely slow, owing mainly to labor conditions. The addition on the east, covering the 40 foot lot purchased last year, was sufficiently completed the middle of April to permit of the transfer to it of several departments. At the present time, the outlook is that the complete building will be ready for occupancy sometime late in the fall.

When completed, the Association will own a building, 160 feet on Grand Avenue and 100 feet on Dearborn Street, with six stories and a high basement, of steel and concrete construction—a building which, while not ornate, will be substantial, a credit to the Association, and well fitted for the purpose for which it has been constructed.

REDUCTION IN DUES

At the last meeting of the House of Delegates, the By-Laws were modified authorizing the Board of Trustees to change the annual dues, under certain limitations. At its last meeting, the board favorably considered reducing the annual dues and subscription to the old rate of $5. Final action will be taken at the October meeting, and unless unforeseen developments warrant otherwise, the board will at that time order this decrease put into effect.

REORGANIZATION OF THE BOARD OF TRUSTEES

It is the unanimous opinion of the Board of Trustees that the three-year period of Trusteeship is too short to enable a member to gain a sufficient knowledge of the affairs of the Association to make his services of real value; that it takes two years before he becomes thoroughly acquainted with all its various activities. Further, the three-year term and the election of three members annually may result in a majority of the board being replaced by new members in too short a period; in fact, this has occurred: In 1907-1908, within a period of approximately twelve months, five new and inexperienced men were elected to membership on the board. Since 1883, at the time The Journal was started and the board created—forty years—fifty-nine Fellows of the Association have served as members of the Board of Trustees: twenty-three, from one to three years; seventeen, from four to six years; eight, from seven to nine years; five, twelve years, five, fifteen years; and one, eighteen years.

The board unanimously recommends that the term of service shall be five years and that a Fellow shall not be eligible to serve more than two consecutive terms as a Trustee. In the case of an election to fill a vacancy caused by the resignation or death of a member, the new member shall be regarded as having served one term, provided he has served three years.

The president, the president-elect, the speaker and the Board of Trustees all have certain duties and responsibilities in the administration of the affairs of the Association and the carrying out of the policies adopted by the House of Delegates. There should be co-operation of all these. The board believes that this co-operation would be more easily accomplished and the duties and responsibilities carried on more efficiently if the president, the president-elect and the speaker were ex-officio members of the board. As the Association is incorporated in Illinois, and the statutes of the state place the responsibility for the administration of financial affairs and the care of the property of a corporation upon the board of directors—in this case, the board of trustees—who are duly elected members of that body, it was considered wise to consult the attorneys of the Association regarding the matter. The attorneys have given the opinion that the president, president-elect and speaker may be ex-officio members of the board without the right to vote, but otherwise to have equal power with the duly elected members.

It has been the practice of the board recently to invite these officers to attend its meeting, and the board of trustees now recommends that the constitution and by-laws be changed to make these officers ex-officio members of the board.

BUREAU OF LEGAL MEDICINE AND LEGISLATION

At the annual session in 1922, last year, you authorized the board of trustees to create a bureau of legal medicine and legislation; the activities of the Association along these lines had, since 1910, been under the jurisdiction of the council of health and public instruction. In accordance with this authorization, the board of trustees established this bureau, and elected as its executive secretary Dr. W. C. Woodward, formerly commissioner of health of the District of Columbia, and later of Boston. Dr. Woodward is especially qualified for this position, not only because of his active work in the past in public health and medicolegal matters, but also because, while a resident of Washington, he had much experience in connection with federal legislation as pertaining to the District of Columbia. He is further qualified because he has had legal training and holds a degree of Master of Laws. His report for the year to the board of trustees will be found among the addenda to this report. Dr. Woodward will present an abstract of his report to the house.

DEATH OF DR. ALEXANDER R. CRAIG

On September 2, 1922, Dr. Alexander R. Craig, Secretary of the Association, died at his country home in Maryland.

The majority of the Fellows and members of the Association never will know the loss sustained in the passing of Dr. Craig. He was so modest, so free from any assumption of unusual knowledge and so entirely devoid of a dictatorial spirit that his great influence made itself known by accomplishment rather than by a display of effort to bring about results. His advice and counsel were especially valuable in the many difficult problems presented in the program of organization of the profession which came under the jurisdiction of his office. He was always able to see the point of view of the other fellow, and his adherence to the principles of the Golden Rule enabled him to bring harmony out of what gave promise of discord. He not only filled the position of Secretary of the Association efficiently, but he was also the secretary and executive officer of the Council on Scientific Assembly and of the Judicial Council. As secretary of the Judicial Council, his character and exceptional tact were evident. He was a rare type of man, with a spirit devoted to service for this Association, which he loved.

On the death of Dr. Craig, Dr. Olin West, the Field Secretary of the Association, was assigned to the work of the Secretary, and at the meeting of the Board of Trustees held Nov. 16, 1922, Dr. West was appointed Secretary of the Association for the unexpried term.

A. M. A. BULLETIN COMPLIMENTARY TO FELLOWS

In his report, the Secretary recommends that the A. M. A. Bulletin be sent complimentary to Fellows of the Association, as well as to officers of state

and county societies as at present. The Trustees endorse this recommendation.

AN APPRECIATION

For a period of twenty-five years, Dr. George H. Simmons has devoted his entire time and energy to service for the Association. The members of the board are unanimously of the opinion that an expression of appreciation should be made to him at this time. As Editor and Manager, he has manifested remarkable literary ability, and it is due chiefly to his editorial management that The Journal is recognized as the foremost general medical publication of the world, with a circulation at home and abroad of 80,000 copies weekly. He has shown rare and efficient administrative skill, which has won the respect and confidence of all the general officers, the members of the Board of Trustees, the members of the councils and committees, the personnel at headquarters, and the Fellows of the Association who have been fortunate enough to come in close contact with him. He has been honest, individually unselfish, loyal, and his efforts have been productive of the greatest service to the Association.

Respectfully submitted,

Oscar Dowling,
Charles W. Richardson,
D. Chester Brown,
W. T. Sarles,
A. R. Mitchell,
Walter T. Williamson,
Frank Billings,
Wendell C. Phillips,
Thomas McDavitt.

REPORT OF THE BUREAU OF LEGAL MEDICINE AND LEGISLATION

To the Board of Trustees:

The creation of a bureau of legal medicine and legislation, at headquarters was authorized by recommendations made by the reference committee on legislation and public relations, on hygiene and public health and on reports of officers, all adopted at the St. Louis session by the house of delegates. The scope of the proposed bureau was stated at some length in the report of the reference committee first named, as follows:

> The committee recognizes in the several reports of officers, and in the report of the Council of Health and Public Instruction, a consensus of opinion that a central bureau should be established for the consideration of all legislative matters pertaining to medicine or the practice of medicine, and of the public health, relieving the Council on Health and Public Instruction of these duties, which must be carried out in view of the extension of the functions of the Council in the matter of public education and it is recommended:
>
> 1. That the trustees be memorialized to establish a bureau of this character, under whatever name, with such whole-time assistance as may be necessary, the duties of which shall pertain to legislative matters and medicolegal problems in which the whole medical profession may be interested, and which shall be to a (a) coordinate the activities of the several constituent state associations, (b) ascertain and crystallize the opinions of the medical profession and the said constituent state associations, and (c) represent the American Medical Association.
>
> In this connection, your committee desires to point to the desirability of the national organization reflecting the will of the great bulk of the medical profession, and that the bureau contemplated and these recommendations should act in matters of general policy, following instructions of the House of Delegates, or in emergencies following expression of opinion from the proper authorities of the several constituent state associations.
>
> In this connection, further, it is recognized that the details of organization and operation of the contemplated bureau may not be decided upon at this time. The discussion of this problem in the report of the Council on Health and Public Instruction is referred to.

Having been appointed executive secretary, I entered upon my duties, June 9. I respectfully submit the following report of my activities for the year next ensuing. The following are the more important matters that have come before the bureau during that period:

NATIONAL PROHIBITION ACT

The following resolution, adopted by the house of delegates, was referred to the Bureau of Legal Medicine and Legislation for action:

> Whereas, The medical profesion has been subjected to criticism and unfavorable comment because of present conditions associated with the enforcement of the Volstead law, and
>
> Whereas, The results of a referendum conducted by The Journal of the American Medical Association, covering 54,000 physicians, indicates that 51 per cent of physicians consider whisky "necessary" in the practice of medicine, and
>
> Whereas, The dosage, method, frequency and duration of administration of this drug in any given case is a problem of scientific therapeutics and is not to be determined by legal or arbitrary dictum, and
>
> Whereas, The experience of physicians, as reported in The Journal, indicates that the present method of control, limitation of quantity and frequency of administration, licensure and supply of a satisfactory product constitutes a serious interference with the practice of medicine by those physicians who are convinced of the value of alcohol in medical practice, therefore be it
>
> Resolved, That the House of Delegates of the American Medical Association in convention assembled, representing a membership of over 89,000 physicians, appeals to the Secretary of the Treasury and to the Congress of the United States for relief from the present unsatisfactory conditions, and recommends that provisions be made for supplying bonded whisky, for medicinal use only, at a fixed retail price to be established by the government.

An appeal was made to the Commissioner of Internal Revenue to limit the distribution of whisky for medicinal use to whisky bottled in bond, except in those cases in which the quantity ordered by the physician did not correspond with the quantity in any such container. As a result of that appeal and of the activities of other agencies toward the same end, the Commissioner of Internal Revenue, with the approval of the secretary of the Treasury, Dec. 22, 1922, issued Treasury Decision No. 3418, which provided that after April 1, 1923, only such spirits, not including alcohol, as are bottled in bond may be withdrawn for medicinal purposes from distillery warehouses and other like establishments. This decision will gradually make bottled-in-bond liquor available in all retail pharmacies holding retail liquor permits. The advisability of restricting retail sales to bottled-in-bond packages and providing for the issue of packages in such sizes as will make such retail distribution convenient and economical is now under consideration in the office of the prohibition commissioner.

Wholesale liquor permits issued only to venders of "patent" and proprietary medicines. The prohibition commissioner, March 17, 1923, notified a firm of pharmaceutical chemists that had applied for a wholesale liquor permit that such a permit could not be issued because the firm did not sell "patent" and proprietary medicines. The matter was brought to the attention of this bureau, which thereupon took the matter up with the prohibition commissioner. The firm directly affected by the demand, although it had not theretofore sold "patent" and proprietary medicines and had no desire to engage in the business, put in a stock of such articles in order that the business of the establishment might not be interfered with, and thereupon a wholesale liquor permit was issued. It is to be presumed, of course, that the ruling and practice of the prohibition commissioner, with respect to the sale of "patent" and proprietary medicines, is general in its application. An effort is being made, therefore, to find the basis for it, so that corrective action may be instituted.

HARRISON NARCOTIC LAW

Proposed inquiry into narcotic addiction. At the

St. Louis session, the house of delegates adopted the following resolution:

Resolved, That the House of Delegates of the American Medical Association approve House resolution number 258 (House of Representatives, Washington, D. C.), providing for a select committee of fifteen to inquire into the subject of narcotic conditions in the United States, the personnel of the Congressional committee to include all physicians who are now members of the House of Representatives.

The resolution then pending in congress, to which the resolution of the house of delegates related, lapsed at the close of the sixty-seventh congress, March 4 last, not having been acted on.

Reduction of tax under Harrison Narcotic Law. An effort has been made to procure a reduction in the tax imposed on physicians under the Harrison Narcotic Act, which can be effected only by congress. Through the courtesy of Honorable John J. Kindred, a representative from New York and a fellow of this association, a bill to accomplish that end was introduced. The sixty-seventh congress expired without having acted on it. A revision of the revenue act of 1921 will probably be undertaken by the congress that is to convene in December next, and the desirability of reducing the narcotic tax imposed on physicians has been brought to the attention of the prospective chairman of the house committee on ways and means, which will have the revision in charge.

Model state narcotic law. There was received, Nov. 16, 1923, from the council on health and public instruction the draft of a proposed model state narcotic law, prepared by a committee of the council in conference with various representatives of the drug trades and others. The representatives of the drug trades have referred this proposed model law to their respective principles for consideration. It has been published in the Bulletin for such action as our several constituent associations may see fit to take with respect to it. Obviously, too, views of the law enforcement officers are essential to a thorough understanding of the situation. The matter of a uniform state narcotic law is now under consideration by the National Conference of Commissioners of Uniform State Laws, through a special committee on the subject.

Narcotic and prohibition regulations to be promulgated only after notice. In prescribing and administering liquor and narcotic drugs, the physician is dominated by two laymen, the commissioner of internal revenue and the secretary of the treasury. They promulgate regulations to which the physician must conform. To these officers, the promulgation of such regulations is merely an incident in a busy day's work, and they must be guided largely by the advice of others. It seems unfortunate, however, that in the selection of their advisers they should have come to rely so largely on officers and employes serving under them, since the views of such men are unavoidably tinged by the official atmosphere in which they live. Certainly, better results would be accomplished were the commissioner of internal revenue and the secretary of the treasury to seek the advice also of the practicing physicians of the country, for that would tend toward a better understanding by the medical profession, and toward simplicity, certainty and practicability in the regulations promulgated.

This entire situation was called to the attention of the commissioner of internal revenue some time ago, and, in connection with a proposed revision of the prohibition regulations, he has since invited suggestions by the bureau. It is now understood that a preliminary draft of so much of the proposed revision as is of interest to physicians will be submitted to the bureau for criticism. Such, however, should be the ordinary course in reference to all regulations; it should be recognized as a matter of right, not a mere matter of courtesy, for the physician to know and to discuss such legislation affecting him as is pending in the treasury department, before it is finally adopted. It is hoped that this point of view will ultimately be accepted by those vested with authority to regulate the practice of physicians in the matter of prescribing liquor and narcotics, without rendering necessary efforts to make it effective through the statutory enactment.

SHEPPARD-TOWNER MATERNITY ACT

The resolution by the house of delegates relative to the Sheppard-Towner maternity act was referred to the Bureau of Legal Medicine and Legislation. It reads as follows:

Whereas, The Sheppard-Towner law is a product of political expediency and is not in the interest of the public welfare, and

Whereas, The Sheppard-Towner law is an imported socialistic scheme unsuited to our form of government, and

Whereas, The Shepard-Towner law unjustly and inequitably taxes the people of some of the states for the benefit of the people of other states for purposes which are lawful charges only upon the people of the said other states, and

Whereas, The Sheppard-Towner law does not become operative in the various states until the states themselves have passed enabling legislation, therefore be it

Resolved, That the American Medical Association disapprove the Sheppard-Towner law as a type of undesirable legislation which should be discouraged.

As the Sheppard-Towner maternity act had already been enacted by congress, the resolution set forth above was directed rather to state activities than to the federal situation. The bureau has confined itself, therefore, to co-operation with the state societies that have sought aid in efforts to defeat lesiglation looking toward the acceptance by the state of the law named. Since the last session of the house of delegates, several states have passed laws agreeing to submit to the terms of the act. Bills looking toward state submission to the terms of the act have been rejected in some instances. The act is now before the supreme court of the United States for the determination of its constitutionality.

REORGANIZATION OF FEDERAL HEALTH ACTIVITIES

A conference was called in Washington, January 17, by Brigadier-General C. E. Sawyer to consider a plan formulated by the joint committee on the reorganization of the administrative departments of the federal government for assembling all health activities of the government except those pertaining to the army and navy, all educational and welfare activities, and the work of the Veterans' Bureau in a proposed executive department, to be known as the department of education and welfare. There were present, in addition to General Sawyer, the surgeon generals of the army, the navy, and the public health service, the president of the conference of state and provincial health authorities of North America and the members of the executive committee of that organization, officers of the American Institute of Homeopathy and of the Eastern Homeopathic Medical Association, the executive secretary of your Bureau of Legal Medicine and Legislation, and others. The plan as submitted to the conference proposed that the department be called "The Department of Education and Welfare." The conference agreed, however, that if the health activities of the federal government are to be included, the department should be known as the Department of Education, Health and Welfare. The plan as officially announced to the public later did not provide, however, for this change of name. Moreover, in the announced plan it was provided that each of the four bureaus of the proposed department should be

under the direction of an "assistant secretary" and not under the direction of a "director general," as proposed in the plan submitted to the conference. The latter change suggests the possibility that the activities of the several bureaus of which the department is to be made up are to be under the direction of political appointees, liable to change with each presidential election, and not under the direction of permanent, technically trained heads. The entire matter will probably come before congress at its next session and should receive now the serious consideration of the association. It might be well for the house of delegates to define its position with respect to the matter and to instruct its officers and councils accordingly.

FEDERAL INCOME TAX

Liability of State Associations. A demand having been made on the Nebraska State Medical Association by the collector of internal revenue at Omaha for returns under the federal income tax law, with a view to the collection of the tax from that association, if any should be found to be due, the matter was referred to the Bureau of Legal Medicine and Legislation. The collector's demand was based on the hypothesis that the association, because it maintained a medical defense service for its members, lost the exemption to which it was entitled as a scientific body not organized for profit. The matter was taken up with the commissioner of internal revenue, who held that the association was not required to make the returns demanded.

Expenses of Attending Meetings of Medical Associations Not Deductable—On or about March 1, 1922, the collector of internal revenue at Marion, Ohio, notified a physician practicing in that city that traveling expenses incident to a meeting or convention of a medical society could not be deducted in computing his federal income tax. The physician appealed to the commissioner of internal revenue, but the commissioner, after having referred the matter to the solicitor, sustained the collector's ruling. The matter came to the notice of the association only through the publication of the commissioner's decision in the internal revenue bulletin of June 26, 1922. Diligent efforts were made to convince the commissioner of internal revenue that the ruling was not justified by the law and the facts in the case and to induce him to rescind it, but without effect. It is possible that relief may be afforded in connection with the proposed revision of the revenue act of 1921, to which reference has already been made. Otherwise, the only remedy is through the courts.

Search of Clinical Records Under Federal Estate Tax Law.—Representatives of the commissioner of internal revenue have recently claimed the right of search, without search warrant, of the private records of a practicing physician, in an alleged effort to determine the extent to which the estate of a person at one time treated by that physician is liable to payment of a federal estate tax. The supposed basis of the claim to the arbitrary right of search is that the deceased patient might have disposed of property some time or other in anticipation of death, for the purpose of relieving his estate of the payment of taxes. The matter has been taken up with the commissioner of internal revenue.

MEDICAL PRACTICE ACTS

The inadequacy of many of our medical practice acts to protect the public against ignorance and fraud has been shown by the efforts that have been made in various state legislatures to procure new or supplementary acts. It is shown, too, by the very large number of chiropractors and others who ply their callings without hindrance from prosecuting officers and courts, in jurisdictions that are protected by what are supposed to be effective medical practice acts. Despite vigorous campaigns for better laws, in only four states, Texas, Oklahoma, Missouri and Idaho, were substantial gains made.

Chiropractors, Osteopaths, Etc. — Chiropractors have been more vigorous during the present year than ever before, in their efforts to gain legal foothold in new fields of activity. Their efforts have always been directed, too, toward establishing themselves as independent of all of the healing arts. Teaching in their schools, as they do, methods of getting business, including the art of self-exploitation, they seem to have little difficulty in raising large sums of money from their following, who get out of their contributions in the way of advertising much more than they put in . During the past year, too, they have adroitly gotten much free advertising out of the press of the country, and have won much ill-bestowed sympathy, through deliberate violations of the law and insistence on going to jail to pay the penalty, rather than pay even a small fine. This method of self and group exploitation is seemingly an integral part of their campaign for legislation, and, in order to mitigate any supposed hardship that might otherwise fall on chiropractors who go to jail, an organization is maintained which undertakes to pay the office rent of chiropractors while they are serving jail sentences in communities in which legislation is being sought, and to compensate them at the rate of $100 per month while they are serving their terms. To see legislators seriously considering the demands of such men for the legal recognition of a cult that teaches that head lice, syphilis, gonorrhea, tuberculosis, typhoid fever, appendicitis and other diseases cannot exist without a displacement of one or more vertebrae and can be cured by replacement, makes one wonder whether after all those psychologists who gaged the mental age of the American people at 14 years, did not place the figure much too high.

In California, where liberal provisions had already been made by law for licensing chiropractors, osteopaths, and all other healers under liberal conditions, both chiropractors and osteopaths carried their respective issues before the people, under the initiative, and had them voted on at the state election. Public attention was attracted to the movement by the procuring of jail sentences for law-breaking chiropractors, and by all other available means of publicity. In their campaigns, organized chiropractors spent $64,211, and organized osteopaths $40,481. How much was spent by individual and by unorganized groups is not known. The result was, however, the adoption of both measures. California has now a board of chiropractic examiners and a board of osteopathic examiners, independent of rational contacts or supervision. Laws creating independent boards of chiropractic examiners were passed by the legislatures of Nevada and Tennessee. Similar laws were defeated in Alabama, Ohio, South Carolina and Wyoming.

Basic Medical Science Bills.—In an effort to require as nearly as may be possible adequate basic training of all who practice the healing art in any of its branches, so-called basic medical sciences bills were submitted to the legislatures of Maine, Minnesota and Wisconsin. These bills have sought to create in each state a non-medical board to examine all applicants in the so-called basic sciences, namely, anatomy, pathology and physiology. Applicants passing the examination were to be certified by the board for further examination by the medical licensing boards and the chiropractic, osteopathic and other such boards, where they exist. In this way, none of the boards last named could lawfully exam-

ine a candidate who had not had an adequate basic medical training, as certified to by the state board of examiners in the basic sciences. These bills uniformly met strenuous opposition from the groups that frankly recognized that their members were without knowledge of the basic medical sciences, and by reason of that fact, they were uniformly defeated.

ANIMAL EXPERIMENTATION

Organized forces opposing the use of animals for research have been active during the year. In congress, a bill was introduced to prevent the use of living animals for experimentation in connection with the army and the navy. In California and in Colorado, under the initiative, proposed laws forbidding animal experimentation came before the people to be voted on, November 7. In Louisiana and New York, bills were introduced to prohibit the use of dogs for research. In the Ohio legislature and in the Denver city council, measures were introduced to permit to be delivered to medical schools, for educational and research purposes, vagabond dogs duly impounded. None of these measures were enacted.

The situations which arose under the initiative in California and in Colorado, and a similar situation that arose under the referendum in the state of Washington with respect to the medical inspection of school children, emphasize the necessity for effective state-wide organization on the part of our constituent associations, particularly in those jurisdictions in which the initiative and referendum may be called into operation. The problem of enlightening legislatures directly and through their constituents as to the fallacies of proposed legislation is much less difficult than the problem of enlightening the people individually and as a whole, so as to induce them to vote wisely. In any event, however, whether the effort is to secure wise legislation through the legislature or by direct vote of the people, events have abundantly proved the necessity for effective organization throughout each state.

CO-OPERATION

Field Work.—The executive secretary has endeavored to meet as far as possible the wishes of constituent associations desiring his presence within their several jurisdictions. Two visits have been made to Colorado, three to New York state, and one to Connecticut and to Ohio. Visits to Washington have been made at various times for conferences with the commissioner of internal revenue, Brigadier-General Sawyer and others, on the business of the association. He attended the annual meeting of the American Public Health Association in Cleveland, the Ohio State Medical Society in Dayton, Ohio, the Connecticut Conference of Social Agencies in Hartford, Conn., and the National Anti-Narcotic Conference in Washington, D. C.

Office Activities.—A large volume of correspondence has been conducted with our several constituent associations and their members, with respect to matters of legislation, medical defense, income tax law, the national prohibition law, the Harrison narcotic law and other matters. An effort was made during the legislative sessions of the past year to keep as closely in touch as possible with state activities, but with only fair success. It is hoped that as time goes on, and as our constituent associations come to realize that the bureau is the best agency through which each association can help all others, and through which it can obtain help from all others, the bureau will be able, through their aid, better to collate and analyze for the service of each of our several constituent associations the experiences of all.

Respectfully submitted,

William C. Woodward,

Executive Secretary.

REPORT OF THE JUDICIAL COUNCIL

To the Members of the House of Delegates of the American Medical Association:

A large number of communications have been addressed to the judicial council during the past year, some of which more properly should have gone to local councils, as they dealt with local ethical matters, the principles governing which are already set forth in the principles of medical ethics. These communications have dealt principally with questions of ethics which should be determined by the boards of censors of component county medical societies, or, on appeal, by the boards of councilors of constituent state medical associations. Of course, appeal from boards of councilors of constituent state medical associations can always be taken to the judicial council of the American Medical Association. The judicial council is not disposed to refuse to accept responsibilities that may be imposed upon it with respect to questions which can best be adjudicated by this council, but feels that the boards of censors of component county medical societies and boards of councilors of constituent state medical associations first should attempt to adjust local matters involving their own members. Adequate machinery has been provided for the fair adjudication and settlement of misunderstandings and disputes between individual physicians, or between physicians and medical societies, and adequate provision has been made for orderly appeal from decisions which may not be acceptable to parties concerned. The judicial council stands ready at all times to give advice or assistance in the settlement of questions which may be presented to boards of censors or boards of councilors; but while it is desirous of being helpful to officers of component and constituent societies, it is also desirous of avoiding even the appearance of interfering with the operations of established agencies of the county and state medical societies.

A great many communications have been received with advertisements used by individual physicians, group clinics, pay clinics and hospitals owned by individuals or groups. Practically all of the advertising that has been thus submitted, some of which has been sent anonymously, has been found objectionable. The council wishes to state, however, that the members of state associations who use objectionable advertising are responsible to and under the control of the censorial agencies of the societies of which they are members. The secretary has been directed, therefore, to refer communications of this nature to the secretary of the constituent medical association concerned, with the suggestion that they should be brought to the attention of the board of councilors, or, through them, to the attention of the board of censors of the component society concerned.

An interesting communication which was presented to the council during the year was one inquiring as to the propriety of the use of radio broadcasting stations by individual physicians for the dissemination of medical information. It is the opinion of the judicial council that radio broadcasting is a form of publicity and its use is subject to the same rules as those which apply to newspaper advertising and, therefore, is to be governed by the ethical principles of the profession. The decision of any special question concerning radio broadcasting in individual

cases falls within the jurisdiction of component medical organizations.

In a communication received from a group clinic, inquiry is made as to the ethics involved in the admission of an osteopath into the clinic group. It seems that an osteopath had actually been admitted into this particular group and that a complaint had been registered with the county medical society. The judicial council is of the opinion that it is not in keeping with the principles of medical ethics of the American Medical Association for members to associate themselves with osteopaths; that the by-laws of component societies not in conflict with by-laws of their state associations or of the American Medical Association cannot be ignored; that under the principles of medical ethics, physicians cannct act with or support those who base their practice on an exclusive dogma or sectarian system; and that physicians associated with an osteopath in a clinic or otherwise cannot be debarred from membership in the American Medical Association in the absence of action by their component society.

From another source, inquiry was made of the right of a county medical society to withhold membership or to withdraw the privileges of membership from a registered physician who graduated from an osteopathic school. This inquiry came from Texas, in which state a diploma from a high grade osteopathic school entitles the holder thereof to take the examination by the state board of medical examiners for a license to practice medicine. This examination must be in all respects the same as that to which a graduate of a medical school is required to submit, and the graduate of the osteopathic school who passes the examination successfully is granted the same kind of license to practice medicine as that granted to a graduate of a reputable medical school. The judicial council is of the opinion that a legally registered physician who has complied with the requirements of the law in securing a license by the state to practice medicine and who, having secured such license, has not practiced or claimed to practice sectarian medicine, but has conformed to the requirements of the principles of medical ethics of the American Medical Association, and who has been accepted into membership in a county medical society, cannot be expelled therefrom without cause.

It seems to be true that a concerted movement has been organized covering most of the states, to secure entrance to "regular" hospitals for osteopaths and chiropractors, and possibly for followers of other sects and their patients. In response to several inquiries, received almost simultaneously, the judicial council formulated and submitted the following opinion:

The board of control of any hospital (not maintained by general taxation) has the legal right for reasons sufficient to the board to refuse the privileges of the hospital at any time to any practitioner regardless of his so-called school of practice. The fact that the person applying for permission to bring to and treat in the hospital a particular patient is licensed by the state to practice does not alter the situation. The medical staff of a hospital likewise has the moral right to refuse to accept as an associate any person whom the staff may consider objectionable for reasons sufficient to the staff, and should insist on maintaining that right.

Section 1 of Chapter XI. of the by-laws of the American Medical Association provides that "a member of a constituent association who removes to, and engages in the practice of medicine at a location in another state in which there is a constituent association, shall forfeit his membership in this association, and the secretary shall remove his name from the roster of members of the American Medical Association unless within one year after such change of residence he becomes a member of the constituent association in the state to which he has moved." Section 3 of Chapter XI. of the by-laws provide that "a fellow who changes the location at which he practices medicine, from the state through his constituent association he holds membership in the American Medical Association to another state in which there is a constituent association, is eligible to membership in the component society of his new location. * * * He shall forfeit his fellowship in the American Medical Association one year after such change of location unless he becomes a member of the constituent association of the state to which he has moved."

A number of the Fellows of the American Medical Association have moved to states other than those in which their membership is held. Some of these are engaged in the private practice of medicine; some are engaged in teaching, and others are engaged in other special lines of professional work. In some instances these Fellows are not eligible to membership in the county societies and state associations of the states in which they have taken up residence, for the reason that they are not legally registered as licensed practitioners in those states. In some instances, these Fellows would be required to submit to an examination by the boards of examiners in order to secure license. For that reason and for reasons sentimental and otherwise, some of these Fellows are greatly averse to relinquishing their membership in the associations of the states from which they have moved.

In the case of a teacher in the medical school of a state university, the claim has been made that he is not engaged in the practice of medicine, since he attends no patients except those seen in the university hospital in the course of his work as a teacher.

The claim is made by some Fellows of the association who have moved to other states than those in which they hold membership that because they are engaged in certain special lines of work, as for instance radiology, they are not engaged in the practice of medicine and that there is, therefore, no occasion for securing license in the states in which they have moved. Without license, they are ineligible in the medical societies of such states. They, therefore, wish to continue their membership in the societies of the states from which they have moved.

The judicial council is of the opinion that the provisions of the constitution and by-laws of the American Medical Association apply equally to those physicians who practice in institutions and to those in private practice. It is urged, therefore, that Fellows who have removed from one state to another shall seek to secure membership in the component county medical societies at their new locations within one year of the time of removal, in order that they may be continued as Fellows of the American Medical Association, and in order that they may give their active support to medical organization in the communities in which they have taken up residence.

The house of delegates, at St. Louis in 1922, provided for the appointment by the president of a special committee for revision of the principles of medical ethics. The president appointed the judicial council to serve as that committee. After a careful study of the principles of medical ethics, the following amendments are recommended:

The heading to Section 2, Article I, Chapter II., page 6, should read "Medical societies" rather than as it now reads, "Duty of Medical Societies."

The heading of Section 1, Article III., Chapter II.

page 11, should be changed by the substitution of the word, "Encouraged," for the word, "Required," so that this heading should read, "Consultations Should Be Encouraged."

The word, "may," in the third line of Section 5, Article III., Chapter II., page 13, should have substituted for it the word "should," so as to make the first three lines of this section read, "After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to," etc.

The following sentence should be added to Section 1, Article IV., Chapter II., page 15, at the end of the section: "In embarrassing situations or whereever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow."

The fourth line of Section 1, Article VI., Chapter II., page 18, should be changed by the elimination of the words, "by societies," and transposition of the word "endowed," so that this line shall read, "physician. But endowed institutions," and

Section 1, Article VI., Chapter II., page 19, should be further changed by the elimination of the words, "should be accorded no such privileges," which now appear at the end of that section, and the substitution therefor of the words, "have no claim upon physicians for uncompensated services." These changes will make Section 1, Article VI., Chapter II., read as follows: "Section 1.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for uncompensated services."

The heading of Section 2, Chapter III., page 20, should be changed by the substitution of the words, "Public Health," for the present heading of this section.

No other changes are thought to be necessary.

M. L. Harris, Chairman.
W. S. Thayer.
I. C. Chase.
J. N. Hall.
J. H. J. Upham.
Olin West, Secretary.

REPORT OF THE COUNCIL ON HEALTH AND PUBLIC INSTRUCTION

To the Members of the House of Delegates of the American Medical Association:

At the St. Louis session it was voted to recommend:

That legislative and legal matters heretofore referred to the council be transferred to the Bureau of Legal Medicine and Legislation to be created by the board of trustees with a full-time secretary.

That a sum of $200 be appropriated for the National Health Council; that the chairman of the council be the delegate of the Council on Health and Public Instruction to this organization.

That the pamphlets of the Council on the Protection of Scientific Research, about 28 in number, be condensed into two or three pamphlets under the supervision of Dr. Cannon of the council .

That the pamphlets in the series on the Conservation of Vision, on Cancer, and on other subjects be revised and condensed into a smaller number by suitable committees, to be appointed for that purpose.

That the secretary of the council be authorized to use a sum not to exceed $3,000, if available or procurable, for the purpose of providing such educational material (addresses, syllabi, charts and other illustrated matter) as the present immediate demands of the medical profession may make useful for the instruction of the public.

The suggestion that food charts be prepared by the council was not approved.

It was also voted not to publish a manuscript on "The Venereal Peril" which had been prepared.

The chairman and the acting secretary of the council were directed to advise with the board of trustees in selecting a permanent secretary .

It was voted that the council invite the Medical Women's National Association to select a committee to co-ordinate the activities of their association with the work of this council.

It was voted that it would be in the interests of health and honesty in medical practice if existing statutes relative to obscenity and crime were amended so as not to hamper the licensed physician in advising his patients in the matter of prevention of conception with the proviso that he is given no right to advertise or exploit such means in any way whatsoever.

It was voted to recommend that the council be authorized by the house of delegates to prepare suitable forms for the examination of persons supposedly in health, and that county medical societies be encouraged to make the announcement that their members are prepared and ready to conduct such examinations; only the indigent to be examined free of charge, all others to pay for such examinations.

The secretary reported that a total of 141,500 pamphlets has been sent out in response to requests during the previous year.

MEETING OF THE COUNCIL, NOVEMBER 16-17

At its meeting, November 16-17, in Chicago, Dr. Vaughan was elected chairman for the ensuing year.

It was voted to send a complete file of the publication of the council to the National Health Council Library.

That Dr. Daniel Morton, who had prepared a Catechism of Public Health, be requested to submit a full text of it for further examination.

That the Bureau of Legal Medicine and Legislation be requested to use its facilities to secure the passage of the Model Vital Statistics law in the three states not having such legislation. The bureau was requested to take cognizance of the inadequacy of enforcement of the vital statistics law in many states.

In reference to the new journal for the laity, the following action was taken by the board of trustees in conference with the council:

(a) The name of the new journal will be: "Hygeia, A Journal of Individual and Community Health: Founded and Published by the American Medical Association."

(b) The journal shall appear as a monthly publication.

(c) Each issue shall consist of about 64 pages of double column reading matter set in double leaded ten point.

(d) The price of the journal will be three dollars a year, or twenty-five cents per copy.

The chairman of the council made the following recommendations which were approved by the board of trustees:

(a) The editorial control of the journal shall be vested in the Council on Health and Public Instruction with such assistance as this council may require.

(b) The executive editorial committee shall consist of Victor C. Vaughan, Arthur J. Cramp and Morris Fishbein.

(c) The Council on Health and Public Instruction will not prepare a budget for the expense of

running the journal. All such expense shall be submitted to the general manager, and it is expected that the board of trustees will pay all bills approved by the Council on Health and Public Instruction and endorsed for payment by the general manager.

In reference to narcotic drugs, the following action was taken:

The report of the conference with representatives of the professional organizations of the dentists, pharmacists, and of veterinary surgeons and of the drug manufacturing and trade organizations was accepted, and it was ordered that the draft of the proposed model state Narcotic Drug Law be transmitted to the legal bureau of the American Medical Association, with the recommendation that it be not altered without notifying members of the conference group of the proposed changes and reasons therefor.

It was voted that the preparation of literature dealing with smallpox and vaccination shall be in the hands of the Council on Health and Public Instruction, and its distribution shall be supervised by the Bureau of Legal Medicine and Legislation.

The chairman was authorized to appoint a committee to confer with Dr. Meanes of the Women's Foundation for Health, as to the revision of the booklets in the Positive Health Series of the Foundation.

It was voted that $500 be appropriated for the financing of the educational propaganda of the council through the women's organizations where these expenses are not properly a charge on the Women's Foundation for Health or one of the constituent organizations.

It was ordered that an item be included in the next budget to defray the expense of advertising in the lay magazines the educational publications of the council, and to cover the cost of revision of these pamphlets pending such time as revised texts may be publihsed in Hygeia.

The chairman, as editor of Hygeia, was authorized to appoint an editorial board to advise with him and the council on the policy and material for publication in Hygeia.

The Conference of State Secretaries was requested to suggest members of a committee to confer with the council on the preparation of forms for Periodical Examinations of persons supposedly healthy.

Statement of expenditures of the council was presented by Dr. West, acting secretary, showing a total expense for the year 1922, up to November 1, of $12,933.78, leaving a balance of $8,151.22. Detailed report is shown on a subsequent page. He also made report on the publications of the council.

COUNCIL MEETING, MARCH 16-17, 1923.

The chairman of the council stated that the first number of Hygeia was ready and that a subscription list of 12,800 had been secured.

Dr. John M. Dodson was appointed as acting secretary of the council and editor-in-chief of Hygeia.

A report of the subcommittee co-operating with the National Education Association for the study of Health Problems in Education was presented and placed on file. The report showed very gratifying progress in this important movement, and that a detailed program of training and education for health in the public schools, from the kindergarten through the normal school, is now in process of preparation by the joint committee and a technical committee of expert educators.

It was voted that Dr. Cannon be appointed a committee of one to prepare a Source Book on Protection Medical Research and also to revise and condense the pamphlets on this subject for reprinting and lay distribution.

A blank form for periodic medical examination of presumably healthy persons was presented by Dr. Emerson, discussed by members of the committee of the conference of state secretaries. It was ordered that Dr. Emerson, with Doctors Sleyster, Throckmorton, Hines and West, of that committee, be requested to revise the form and accompanying text in accordance with suggestions made in the discussion; to prepare a final text as soon as possible with authorization to publish it in the American Medical Association Bulletin as soon as ready.

The council recommended an appropriation of $250 for the National Health Council for the current year.

It was voted that the board of trustees be requested to appropriate the sum of $25,000 for the work of the council for year 1923.

It was voted to hold a meeting of the council each year at the time and place of the session of the American Medical Association, this year in San Francisco, the place and exact time to be arranged by the chairman.

The reports of the subcommittees on Health Problems in Education are appended.

The reports of the subcommittee on Narcotic Drugs, and of the committee on "Periodic Examinations of Healthy Persons" were printed in the A. M. A. Bulletin for April, 1923, copies of which will be distributed to the house of delegates.

There is a continuous and steady demand for most of the pamphlets published by the council. The report to date is as follows:

Series	No. of Vols. in Series	Calls for in 1922	No. Now on Hand
Infant Welfare	7	235,520	81,176
Sex Education	5	11,300	11,325
Public Health	8	60,290	4,200
Health Problems in Education	4	3,200	15,470
Cancer	10	3,279	8,975
Conservation of Vision	20	4,432	14,950
Protection of Research	28	2,300	23,310
Miscellaneous	9	200	16,100
Totals	91	320,521	175,506

REPORT OF THE JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION

To the Council on Health and Public Instruction of the American Medical Association:

The second annual conference of the committees of the several state medical societies on health problems in education was held in St. Louis, May 23, 1922. Addresses were given by Drs. Welch of Alabama, Rankin of North Carolina, Leathers of Mississippi, McCormack of Kentucky, Hager of Maryland and Leiser of Washington. It is recommended that no further conferences of this sort be held until the members of the state committees have expressed a desire for such.

At the meeting of the National Education Association in Boston last July, $1,000 was appropriated for the work of the joint committee, and it was recommended that a similar amount be appropriated for the use of the committee. The National Education Association also appropriated $1,500 for the special work of the joint committee in drafting a comprehensive program of health education. It is not expected that this special appropriation will be duplicated by the American Medical Association.

Dr. Wiliam B. Owen, member of the joint committee, was elected president of the National Education Association for the current year.

Two important reports were issued by the joint committee during the summer of 1922, namely, "Health Improvement in Rural Schools" and "Health Service in City Schools." An edition of 5,000 copies of each of these reports has been printed for distribution in response to demand. The report of the chairman of the joint committee, Dr. Wood,

under date of June 19, 1922, presents an admirable summary of the activities of the committee for the last decade and of its plans for future work.

Your Committee on Health Problems in Education would recommend that diligent effort be made during the ensuing year to arouse greater activity on the part of the committees of the several state medical societies approved by the house of delegates at its meeting in New Orleans. This can be most effectively accomplished by personal contact, and we would recommend that the secretary of the council or some member thereof or some member of your committee on Health Problems in Education attend as many as possible of the meetings of the state medical societies during the coming year.

A meeting of the joint committee was held in Cleveland, March 1, 1923, at which were present eight members of the National Education Association group and two members of the American Medical Association contingent. At this meeting a detailed report was made by Dr. Wood of the progress of the technical committee in preparing a program of health education. Mrs. Ira Couch Wood presented for the special committee on ventilation and heating a report somewhat revised from that of last year. In brief, the essence of this report is that ventilation by open windows and ventilator shafts for outgoing air is more effective than any of the mechanical systems. This report is to be submitted to each of the members of the joint committee. When finally revised as approved, it was recommended that an edition of 5,000 copies be printed.

It was voted to print 5,000 copies of the report on "Daylight in the Schoolroom," prepared by a special committee, of which Dr. Edward Jackson was the chairman.

Attention is called to the fact that again this year the American Medical Association and the National Education Association will hold their annual meetings in close proximity as to time and place. This committee would recommend that the house of delegates appoint a committee of the American Medical Association to attend the meeting of the National Education Association in Oakland to convey greetings from the American Medical Association and express the great appreciation of the medical profession for the prompt and satisfactory response of that organization to the request made by the American Medical Association, at its session in Los Angeles in 1911, that more attention be paid to health problems in education.

Approved.

Victor C. Vaughan, Chairman.
W. S. Rankin.
Haven Emerson.
Milton Board.
W. B. Cannon.
John M. Dodson, Secretary.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

To the Members of the House of Delegates of the American Medical Association:

The present report of the council makes reference to (1) the progress of the year in medical education; (2) the problems in medical practice; (3) hospital improvement; (4) nurse education and service, and (5) graduate and postgraduate medical schools.

1. PROGRESS OF THE YEAR IN MEDICAL EDUCATION

Since our report a year ago, the number of medical schools in the United States has decreased from eighty-three to eighty-one through the closing by the state universities of Michigan and Ohio of their separate homeopathic medical schools. It is interesting to note that the number of medical schools at the present time is just half the number that existed in 1906, when there were 162 colleges—the largest number—which was more than half of the world's supply and many more than were really needed in this country.

MEDICAL COLLEGES

A new medical school is being established on an elaborate plan by the University of Rochester, N. Y., and is expected to begin active teaching in 1924. Two state university medical schools, those of Wisconsin and Missouri, which now offer only two years of the medical course, are enlarging their plants in order to give the full four-year course. During the last fifteen years, in addition to many new, enlarged or remodeled buildings in medical schools, greatly enlarged medical plants have been established in eleven universities; (1) similar large plants are now under construction in five other universities; (2) and plans for large plants have been prepared for still six others, (3) and construction of the buildings will begin in the early future.

MEDICAL STUDENTS

In 1919, the total enrollment in all medical schools was 13,052—the lowest number recorded since 1890. Of this number, however, approximately 90 per cent possessed higher educational qualifications (4) as compared with only 6.2 per cent in 1904. Since 1919, the total enrollment (Table 1) in all medical schools has increased at the rate of about 1,000 students each year, the total in 1922 being 16,140, and an estimate based on reports from all but a few of the schools shows that the present enrollment is approximately 17,700, the largest enrollment since 1912. There is now an average of 218 students in each of the eighty-one medical colleges, as compared with 176 students in each of the 160 medical colleges existing in 1904.

MEDICAL GRADUATES

The class of 2,529 students who graduated in 1922 was small because it was the "war class," made up of the few students who matriculated in 1918. The larger numbers enrolled in the three following years, as may be noted in Table 1, indicate that there will be approximately 3,000 graduates this year, about 3,800 in 1924, and about 4,500 in 1925. The last figure mentioned will bring the annual output of physicians to about what it was in 1907, when there were 4,980 graduates from the 159 medical schools. In 1907 there were only 31 graduates on the average from each college, while in 1925, according to our estimate, the eighty-one colleges will graduate approximately fifty-seven students each. At present, also, more than 90 per cent of all graduates possess higher qualifications in both preliminary and professional education, as compared with less than 10 per cent of those who graduated in 1907.

MEDICAL CURRICULUM

During the last few years, in the conferences on medical education, the need of a reorganization of the medical curriculum has been emphasized. During the campaign for the greatly needed standardization and development of medical education, as the need of instruction in certain subjects was recognized they were added, so the curriculum has grown to be an accumulation of many courses with a certain number of hours allotted to each. The result has been the development of a more or less rigid

1. These universities are Cincinnati, Georgia, Emory, Johns Hopkins, Harvard, Indiana, Minnesota, Nebraska, St. Louis, Washington and Yale.
2. Universities of Colorado, Illinois, Oregon, Rochester, N. Y., and Wisconsin.
3. Universities of Chicago, Iowa, Northwestern, Ohio, Vanderbilt and Western Reserve.
4. Two or more years of college work in addition to a four year high school education.

curriculum in which the various laboratory subjects are taught in so-called "water-tight compartments." There is now a general movement in teaching to secure a better correlation between the laboratory and clinical subjects. One marked improvement has already been made. Instead of allotting in a detailed manner a specified number of hours to each minute subject in the curriculum, each laboratory and clinical department is allotted a total number of hours, which may be used by that department in the manner that will produce the best results. Thus the head of the department is free, if he thinks wise, to establish courses in cooperation with other departments, whereby a student may see the application in the clinic of the ideas he has just obtained in the laboratory.

IMPROVED TEACHING PLANTS

Another step toward bringing about a better correlation between laboratory and clinical subjects is indicated in the plans for new teaching plants which are already in process of construction or which have been adopted by several of our prominent university medical schools. The plans for the new hospitals of the Universities of Chicago, Colorado, Rochester, Vanderbilt, and others place the medical school and hospital in the same building where the laboratories are in intimate contact with the hospital wards. Such an arrangement will bring the medical student throughout his medical course in constant contact, not only with the teachers of both laboratory and clinical departments, but also with interns, house physicians, and the members of the attending staff, all in the same building where sick people are being constantly cared for. All will have a common meeting ground in the medical library, which will also be in the same building.

This single building arrangement is in marked contrast with medical schools where the laboratories are widely separated from clinical departments, the latter sometimes being in separate and distant cities. The extreme situation is found in the two-year medical schools where the student goes necessarily not only to a distant city, but also to a different medical school for his two years of clinical instruction.

The tabulation gives also, comparatively, the numbers of hospitals in the various states in the years 1921 and 1923. The number in the latter year in some states is smaller than in the previous year, owing to the fact that more than 500 "homes"' 'have been eliminated from the list, since they were found not to have hospital departments. Names of several hospitals that have ceased to exist have also been struck from the list. The number of hospitals now total 6,570, a net increase of 334 since 1921.

2. PROBLEMS OF MEDICAL PRACTICE

The rapid expansion of medical knowledge has brought with it several problems in medical education and practice, including:

(a) The modern training of general practitioners. The training of the general practitioner is a matter of special importance since they should always constitute the great majority of physicians and will be called on to care for patients representing all varieties of diseases and injuries. This is a problem for further study by the council in the early future.

(b) The training of the specialist.—Part 5 of this report deals in full with this subject.

(c) The relationship of the general practitioner to the specialist and the proportion of each type which is needed.—Reliable estimates are that from 80 to 90 per cent of all cases of illness can be properly cared for by well qualified and resourceful general practitioners. While there is a legitimate and important field for properly trained specialists, therefore, the need of them should not be over-emphasized. The trouble at the present time is that many physicians are posing as specialists without having first obtained the essential training .

(d) The proportion of patients which require hospitalization.—A reliable estimate states that over 90 per cent of all patients can be cared for efficiently in their homes or in the physicians' offices without the need of the hospital.

(e) The development and function of group practice.—This is dealt with in Part 3 of this report.

(f) The measure by which the benefits of modern medical knowledge and practice can be furnished to the entire public, including the supplying of physicians to rural communities.

SUPPLYING PHYSICIANS FOR RURAL COMMUNITIES

The difficulty of providing care for rural communities is still one of the problems of medical practice. Particularly is this true in communities where the population is scattered or where the physician has to practice under extreme difficulties.

The reasons for the scarcity of physicians in rural districts are mostly economic and are briefly outlined as follows:

(a) Many physicians in rural communities graduated before medical schools had undergone the tremendous developments that have taken place during the last fifteen or twenty years. Although many of these, in spite of handicaps, have kept in touch with the progress in medical knowledge, there are some who, for financial or other reasons, could not get away to secure a postgraduate education.

(b) Recent graduates in medicine naturally prefer to live in the city with its better social, educational and living conditions.

(c) Also, aided by public choice, there has been a rapid trend in recent years for the treatment of patients in hospitals, especially where surgical procedures are required.

(d) Furthermore, with rare exceptions, hospitals are built only in cities where the population is sufficiently large to support them.

(e) With the improved transportation facilities, wealthy people in rural districts have developed the habit of obtaining most of their necessities from nearby cities. They go there, also, to secure hospital care or to physicians who have, or are supposed to have, established reputations.

(f) Except in emergencies, therefore, the country practitioner has only the mild cases and patients who are unable to or do not pay reasonably high fees.

(g) While there always has been a scarcity of physicians in rural districts, the situation became more pronounced when the war called many physicians away from the country districts. Then, at the close of the war, they took the opportunity to obtain postgraduate work and to locate in more favorable communities. Meanwhile, investigation of many rural districts from which requests for physicians have come, shows that in most of them physicians could not make a livelihood without undue sacrifice and difficulty.

It is believed that any community that can support a physician can get one if its citizens are willing to pledge themselves to guarantee an income of from $2,500 to $3,000 a year and to interest the community in the physician's support. This plan has worked out satisfactorily in a middle west community where the physician selected secured from his practice an income larger than the amount pledged, so that the guarantors have not been called on to pay out any money.

The points in favor of this plan are that (a) the people of the community have a voice [illegible]he selec-

tion of their physician, and (b) the fact that they have pledged themselves to his support will induce them to patronize him so far as is possible and not go to physicians in distant cities. A third point is that many young physicians are short of funds at the time they complete their medical training and will be attracted to places where some reasonable income is guaranteed. Reasonable guaranties from rural districts, it is believed, will be attractive to recent graduates and will bring a physician to any community having a population sufficient to support one.

In New Hampshire, a law has just been enacted which permits any town to appropriate sufficient money to support a resident physician when the town cannot otherwise obtain one.

3. REPORT OF HOSPITAL WORK

The council on Medical Education and Hospitals in its relation to hospitals maintains three main lines of work, namely (1) information about all hospitals, for publication in The Journal and in the Directory, (2) the list of hospitals that furnish acceptable internships, (3) information service bureau, to answer inquiries and give assistance on hospital problems.

Along with the preparation of hospital data for the eighth edition of the Directory, a complete recanvass of all hospitals has been made. As a result, we have published in the Directory, not only revised data on all hospitals, but also a list of special hospitals and related institutions classified according to the kind of cases received, and a revised list of the hospitals approved for internships. The list of special hospitals is published as a convenience to physicians in referring special cases and contains 38 schools for backward and mentally defective children; 52 schools for the blind; 100 children's hospitals; 27 convalescent and rest homes; 59 schools for the deaf; 53 drug addiction and alcoholic sanatoriums; 55 eye, ear, nose and throat hospitals; 49 epileptic hospitals; 243 maternity hospitals; 548 nervous and mental hospitals; 45 orthopedic hospitals; 15 skin and cancer hospitals; 16 schools for speech defects; 577 tuberculosis hospitals; 5 trachoma hospitals.

The mass of data that has been collected from individual hospitals, and now being prepared for publication, will include reliable statistics heretofore unobtainable on such items as number of roentgen-ray departments; clinical laboratories; nurse training schools; hospitals having no resident physicians nor interns; proportion of superintendents having M. D. degree, R. N., or other; capacity and number of hospitals supported by the different units of government, as state, federal, county, municipal, as well as those supported by private means such as individual and partnerships, churches, fraternities and private corporations.

The 627 hospitals that were on the approved list for internships on May 22, 1922, have during the past year been canvassed as thoroughly as was possible by correspondence and otherwise, giving us new data about each institution for the approved list. Twenty hospitals were removed from the list, and 47 have been added, making a net gain of 27, making a total of 654 at present on the approved list. Thirty-seven hospitals that have applied for recognition are being held in abeyance pending the completion of certain improvements. The 654 approved hospitals represent a capacity of 187,314 beds and afford 3,671 internships. These internships include 3,103 in general hospitals, which would be sufficient to absorb the entire annual output of the meidcal colleges in the United States. The other 568 internships are devoted to the various specialties and should be considered as supplementary to a general internship. Women interns are admitted by 183 of the approved hospitals.

Next in importance to the improvement of internships is the hospital information service of the council. The most frequent demands for assistance are concerned with plans for buildings, staff organization and administration problems touching professional ethics. A count of these service calls for certain weeks in the year indicates that the whole number of calls for information and assistance relative to hospitals was over 1,200 per year.

PRESENT NUMBERS OF PHYSICIANS AND HOSPITALS

As shown in Table 3, from figures based on the 1923 edition of the American Medical Directory, there are now 145,966 physicians in the United States, or 590 more than in 1921. There has been a decrease in the numbers of physicians in thirty-two states, but this decrease has been more than offset by the increases in seventeen states. The small increase in the two years is due partly to the small class—2,529—graduating in 1922, the war class, consisting of the few who matriculated in 1918. The proportion of physicians to population is now 1 to ever 724 people.

SURVEY OF GROUP CLINICS

A survey of group clinics was made in 1922 in connection with the council's survey of dispensaries. While this survey was being launched by the council, the trustees of the American Medical Association, in connection with the judicial council, was planning an investigation into the status of group medicine and pay clinics. By common consent the work of actually canvassing the clinics was done by the council on Medical Education and Hospitals, and a preliminary report was made to the trustees and to the house of delegates in May, 1922. A perpetual file of groups is now being maintained, and reports of new groups are added as their existence becomes known.

An outstanding fact about the whole subject of group medicine is the loose way in which the terms "clinics," "group" "diagnostic group," "group practice," "medical group" and a number of similar terms are ordinarily used. Out of a total of 270 groups that have been listed up to the present time not more than 100 would answer to even a liberal definition of group medicine, and still fewer have been found to be actually correlating the services of specialists as a routine in the examination and treatment of patients. Many situations that are learned of as "groups" turn out to be simple business arrangements for the common use of a building, including the sharing of the waiting room, telephone, clerical assistance, nurses, laboratory, roentgen ray and other facilities not available to the independent practitioner. The various types of groups may be thus classified.

1. Closed Hospital Group.—Relatively very few, the members of the staff of a "closed hospital" conducting a "clinic" in a suite of their private offices, and each member of the staff usually collecting his own fee.

2. One Man Group.—More numerous than any other type. Other specialists on salaries or paid on the percentage basis.

3. Diagnostic Group.—Work confined solely to diagnosis.

4. Co-operative Group.—A group more or less closely organized for the purpose of private medical practice, the aim being for each member to be a mature specialist along a chosen line, and to care for work pertaining to his specialty.

(a) Primitive Type: A co-operative organization

composed of general practitioners from the same community.

(b) Departmental Type: A co-operative group organization composed of men, each of whom has already devoted a certain number of years to acquiring a thorough training in some special field of medicine or surgery, and is confining his private work to that specialty.

The geographic distribution of group clinics plainly shows the influence of certain of the larger clinics from which have developed numerous others. The eight states having the highest number of group clinics, without applying a strict definition to the term are:

Wisconsin	36	Indiana	10
Minnesota	31	Washington	10
Texas	28	Arkansas	9
Illinois	13	California	9
Louisiana	11	Montana	9
Michigan	11		

On the average, there were nine physicians connected with each of the groups from which lists were received. This would make a total of approximately 2,430 physicians in the 270 groups listed.

That there is a growth in actual group medicine is certain, but the rate of such growth is hard to ascertain because of the difficulty of obtaining detailed returns from the groups. It is also certain that a large number of groups are dissolved on the death, withdrawal or removal of one or more members, and this prevents the phenomenal growth that is sometimes ascribed to group practice.

Group medicine is a type of practice which, if properly organized and conducted, will afford efficient service to the 15 or 20 per cent of the sick and injured who may require specialized treatment. However, there is an opportunity afforded the groups efficiently to aid the general practitioner in consultations, and in the diagnosis and treatment of his patients. The attitude of the group in its relations to the general practitioner should be characterized by the same fundamental principles and standard of ethics that apply to the individual physician who is called into consultation by the general practitioner.

Some of the larger and properly conducted group clinics are also providing graduate instruction both in general practice and in the specialties. Groups that develop research work and furnish a high quality of treatment can add materially to their service to the profession by providing residentships for those who seek to develop proficiency in the various specialties.

OTHER CLINICS AND DISPENSARIES

The survey of dispensaries and clinics not only gave us the most complete information yet obtained regarding group medicine, but also yielded a mass of facts that have been digested and published regarding dispensaries and clinics and in fact all forms of organizations for the examination and treatment of ambulatory patients.

Excluding group practice the number and classification of dispensaries covered by the survey are as follows:

General dispensaries		935
Special dispensaries:		
Tuberculosis	888*	
Venereal disease	831*	
Nervous and mental	345*	
Baby and child hygiene	566	
Outpatient departments of eye, ear, nose and throat hospitals	37	
Outpatient offices and stations of the United States Public Health Service	139	
Outpatient departments of orthopedic hospitals	16	
Miscellaneous	53	
		2,875
		3,811
Industrial (enumeration not completed)		134
? Total dispensaries known		3,944

*Including special clinics of general dispensaries as follows: Tuberculosis, 221; venereal, 344; nervous and mental, 85. Exclusive of duplications, the total number of individual dispensaries known is 3,294.

The total number of individual patients in all general and special dispensaries within a year is approximately 8,000,000, and the number of visits made by them is approximately 29,500,000 per year.

The survey brought out the fact that whereas the services of dispensaries were formerly almost entirely free, the idea of allowing the indigent to contribute a small amount, has grown until now fully 60 per cent of all the dispensaries of the country receive partial compensation from at least some of their patients. There is evidence that the abuse of medical charity in dispensaries is held down to a reasonable minimum. There is, however, absolute lack of uniformity or consistency in the schedules of charges to dispensary patients.

4. NURSE TRAINING

The suggestion regarding nurse education in the address of the speaker to the house of delegates, May 22, 1922, was referred to the council on Medical Education and Hospitals. In accordance with the instructions of the house, and after conference with the executive committee of the board of trustees, a special committee (6) was appointed to make a preliminary investigation of the problems of nurse education and to recommend what should be done.

The creation of the committee was completed early in November, 1922, and the investigation covered a period of about four months. An extensive exchange of ideas by correspondence was carried on, and the chairman held numerous conferences with groups of physicians, leaders in nursing education, and such members of the committee as were in the eastern part of the country. No complete survey of the nursing field was either possible or necessary, since the detailed report of the recent extensive survey made under the auspices of the Rockefeller Foundation was placed at the service of the committee. The wide extent of the committee's investigation, made in so short a time, is indicative of the vigor and activity of the chairman, Dr. Lovett, to whom a great deal of credit is due. The report presented by this committee to the council is abstracted as follows:

THE EDUCATION OF THE TRAINED NURSE

The growth of the nursing profession has been very rapid. In 1880 there were fifteen training schools for nurses in the United States, with 323 pupils; in 1920 there were 1,755 schools with 55,000 pupils, and the number of women applying for admission to training schools shows no signs of falling off.

The course of study in nurse training schools has not kept pace in educational development with the rapid increase in numbers. As a result, many problems have arisen which require investigation and adjusting by the co-operative action of both physi-

6. This committee consisted of: Dr. Robert W. Lovett, Boston, chairman; Dr. Austin Flint, professor of obstetrics and gynecology, University and Belevue Hospital Medical College, New York; Dr. Lawrence R. De Buys, professor of pediatrics, Tulane University School of Medicine, New Orleans; Dr. Richard O. Beard, associate professor of physiology, University of Minnesota Medical School, Minneapolis; Dr. Thomas McCrae, professor of medicine, Jefferson Medical College, Philadelphia Dr. Winford Smith, superintendent, Johns Hopkins Hospital, Baltimore; Dr. George B. Sommers, superintendent, Stanford University Hospital, San Francisco.

cians and nurses, and not by either physicians or nurses alone. In the hospital the pupil nurse is directly responsible to the superintendent of nurses, but on leaving the hospital, while engaged in private nursing, she becomes responsible to and acts as the assistant of the physician.

The carrying out of a sound scheme of nursing education, therefore, should be a co-operative enterprise between the physicians and the nurses, and differences of opinion should be settled by frank discussion. The best results can be obtained by a united effort of the two professions, and adequate service to the public is the reason for which both these professions exist.

PRESENT STATUS OF NURSE TRAINING

Nurse training in the United States today is not standardized, systematic or uniform in the matter of entrance requirements, length of the course, and methods of teaching. The nurse training schools connected with the great modern hospitals differ widely from those existing throughout the country away from medical centers.

Legislation cannot be looked to as a solution. All states except New Mexico have laws governing the registration of nurses. Wide variations are allowed in entrance requirement and length of course which account, perhaps, for the equally wide variations in the methods of administration of nurse training schools and in the character of the courses offered.

The defects in the training schools of today are:

1. The course, on the whole, is unsystematized, unstandardized, and far from uniform.
2. There is too little systematic instruction in practical work and too much theory, and certainly a lack of correlation between the two elements.
3. Too many of the teachers are poorly qualified.
4. There is too much waste of the pupil nurses' time in uneducational routine work.
5. Many schools are connected with hospitals having utterly inadequate clinical facilities.

CHARACTER OF NURSE TRAINING COURSE

An analysis of twenty-three schools of unreasonably typical character shows that, although the curriculums include the same general subjects, there are wide variations in sequence and methods of teaching. In certain schools, part of the fundamental instruction bears no relation to the nurses' work, and there is a wide variation of time allotted to the subjects taught. In bacteriology it varied from eleven to eighty hours; in nursing procedures it varied from 55 to 222 hours; in dietetics, from 17 to 64, and in chemistry, from 10 to 150 hours. These instances are typical of the lack of uniformity in the curriculums of today.

Theoretical effective class room instruction must be correlated with practical bedside work on patients, and this requires the co-operation of the visiting physician, the head nurse of the ward, and the superintendent of nurses. It is essential that the nurse should be trained in "doing things" as well as hearing why they should be done. There are three fundamental needs: (a) sound fundamental theory stripped of all nonessentials; (b) bedside demonstrations, and (c) practical work on patients to the largest possible extent.

EQUIPMENT OF TEACHERS

In January, 1921, there were in the United States approximately 1,800 schools of nursing and 55,000 students, graduating about 15,000 a year . Many teachers are required, who must be medical men and nurses working in co-operation.

As teachers, the medical men cannot be retained or prepared for this special task. Some will be good teachers and some bad; some will be enthusiastically helpful, while others will be indifferent and frankly bored. The physician lectures about what he pleases, with little or no correlation with his colleagues, or with the school in general. Physicians cannot escape some blame for the present situation, and, if an attempt is made to make the nurses' training an orderly, systematic education, we are sure that physicians will assist with interest and spirit.

Some of the teaching nurses, both intellectually and pedagogically, are often unfit to teach. The teaching nurse has generally drifted into the teaching position by force of circumstances, perhaps without any adaptability. To establish an effective educational scheme will require the education of the teacher nurse; more and better intsructors will be needed in an effective educational scheme, and this most important function of the university schools of nursing should be emphasized and utilized.

WASTE OF THE PUPIL'S TIME

The nurse is to be trained only by educational means and methods. In the training of an artist, a musician, a teacher, a stenographer, the education problem alone is considered; but in the training of nurses the hospital needs come in, and the hospital expenses are conserved by having pupil nurses, for an unprofitably long time, perform duties that should fall to cleaning women, maids, cooks, waitresses, messengers, head nurses, and the like. Reports state that such profitless duties consume about two hours daily, or one-fifth of the nurse's time.

Although the heavy cleaning is supposed to be done by paid workers, the dusting, cleaning and sweeping for the patients under the care of the nurse require in different hospitals from one-half hour to one and a half hours a day or even longer. In many hospitals the time devoted by the student to the cleaning of lavatories, service rooms, bathrooms, care of the linen closets, patients' clothing, the condition of the serving kitchens, and other similar duties, is far in excess of what is of practical value to her training.

Much time also is spent in special routine duties. In some hospitals the nurse gets more credit for making routine records than for caring for the patients. If she has an unusual number of very ill patients, she cannot complete the routine records, or has to slight them. But for her standing in the training school, the routine is frequently more important. A nurse has been known to be severely reprimanded because she had not kept the record of temperature of the ward each hour when she could not leave a very sick patient. Ward routine must be learned by the nurse, but the continuation of it for too long a time is without profit.

Authorities on hospital problems state that hospital organizations of the future should include a permanent staff of paid workers, trained nurses and others. The needs of the hospitals must be met, and the sick cannot be neglected; but the pupil nurse must not be sacrificed to this end. This will mean an increased cost to the hospital for maintaining the training school. The hospitals are none too well supported now, and any additional expense is to be deprecated. Nevertheless, the object of the training school is to educate nurses who are competent to care for the sick; and, if nurse-training is to be put on an educational basis, the expenditure of time on profitless ward routine duties must be reduced.

CONNECTION WITH INADEQUATE HOSPITALS

It is a question how an effective training school can be conducted with such meager clinical facilities as are offered by many hospitals.

A series of instances taken at random from the tables in a recent survey shows how inadequate is the number of patients in certain hospitals as com-

pared with the number of pupil nurses enrolled. For example: One hospital which maintained a training school had a daily average of five patients and five pupil nurses, while seven other hospitals had, respectively, 193 patients and 111 pupil nurses; 193 patients and 22 nurses; 8 patients and 7 nurses; 10 patients and 10 nurses; 21 patients and 15 nurses; 75 patients and 41 nurses, and 40 patients and 27 nurses. Adequate instruction is hardly possible in these institutions, and they should be discouraged from maintaining so-called training schools.

RECOMMENDATIONS

The recommendations of the committee were, briefly:

1. That a committee be appointed, made up of (a) physicians who are competent clinical teachers, (b) representative nurses, and (c) at least one educator who is neither a physician nor a nurse; that this committee be arranged for by the American Medical Association in conjunction with the National League of Nursing Education, each having equal representation and appointing its own representatives, and that the educator be selected by the other members of the committee when appointed.

2. That a standard minimum curriculum for the training of nurses be formulated and put into effect; that this standard define the lower level of the education of the bedside nurse; that the university school of nursing be developed in order to educate more and better teachers for nurse training schools, and that graduate courses of instruction of at least eight months' duration be established for graduate nurses who desire to specialize, to teach, or to become administrators.

3. That the educational standard of nurse training include (a) entrance requirements consisting of a four year high school education; (b) that the length of the course be two years and four months, or twenty-eight months; (c) that the waste of the student nurses' time in noneducational ward routine be greatly reduced; (d) that better teachers from both the medical and nursing professions be secured in the schools; (e) that the character and sequence of the subjects taught, the percentage of time allotted to each subject, and the correlation of practical and theoretical instruction be considered with special care, and (f) that the standard be such that it may be carried out by relatively small as well as the large hospitals.

4. That there be a classification of nurse training schools in which only those which conform to the standard outlined be considered as acceptable.

The committee appreciated the fact that these changes in nurse training schools may cause increased expenses in the hospitals maintaining nurse training schools. Nevertheless, it was believed that the improvements would more than offset this expense in preventing serious results and greater expense which might accrue to the hospitals from the present increasingly chaotic conditions in nurse education.

5. GRADUATE MEDICAL EDUCATION

Since October, 1922, an inspection of all graduate medical schools in the United States has been made by the secretary of the council and Dr. Louis B. Wilson of the Mayo Foundation. Inquiry was made in regard to the opportunities not only for formal graduate study in preclinical and clinical branches, but also for informal graduate study in hospitals through internships, residencies, etc.

Inquiry in each instance was made regarding the corporate character of the institution, its relationships to other institutions, its financial resources and annual expenditures, its teaching resources in laboratories, hospital, dispensaries, libraries and museums, the number and qualifications of its teaching staff, its standards for admission of students, the length and character of its courses of study in various fields, its methods of determining and recording the progress made by its students, and the character and form of certificates granted by the institution.

Two previous surveys of graduate medical schools have been made, the first in 1915, by Dr. Horace D. Arnold of Boston, and the secretary; the other, in 1919, by Dr. Bevan, the chairman of the council, and Dr. Louis B. Wilson, in certain instances in company with Dr. William Pepper, Dr. James Ewing, or other individual members of the council's special committee on graduate medical education.

GRADUATE EXTENSION WORK

The council calls attention to the increasing opportunities afforded to county, state and district medical societies to organize and operate once or twice each year diagnostic clinics such as those which are being conducted by the Tri-State District Medical Society, the Pacific Northwest Medical Association and others, as well as the extension courses of lectures and clinics given under the auspices of the Universities of North Carolina, Pennsylvania, Wisconsin and Washington and by several of the state medical societies and state university medical schools. The council will be very glad to co-operate with any county, state or district medical society in the securing of clinicians or other instructors when it is desired to organize similar courses or clinics. Details in regard to these courses were presented at the conference of state secretaries held last November, and the report containing the discussions was published in the January number of the American Medical Association Bulletin.

The council's present report, however, deals chiefly with the opportunities for study found in various postgraduate medical schools and hospitals.

OPPORTUNITIES FOR PRECLINICAL WORK

In several university medical schools, opportunities for graduate study in the preclinical branches have long existed, usually as a part of the graduate school of the university in which the students are working for higher degrees in arts or sciences. As far as can be seen, there has been no material inthemselves of these opportunities except where gradcrease in the number of graduate students availing uate medical education is being emphasized.

ADVANCED STUDY IN CLINICAL FIELDS

The demands for advanced instruction in the clinical fields come from two groups of physicians: (1) Those desiring to prepare themselves for the practice of some specialty, and (2) those desiring to improve themselves in general practice or in the practice of a specialty in which they are already engaged.

1. Long Term Students.—The first group consists largely of (a) recent graduates who wish to fit themselves in a special field, either preclinical or clinical, and usually without having engaged in general practice as a means of livelihood; or (b) older graduates who have been in general practice for several years and who wish to fit themselves for, usually, special practice in some clinical field, using their experience in general medicine as a basis for their further study.

The larger numbers of graduate students in both of these groups are still obtaining their preparation informally in advanced internships, residencies, assistantships, apprenticeships and various minor teaching positions in medical schools and the hospitals attached thereto. Their ability to practice in a chosen field is usually a matter of self-determination, occasionally aided by advice from their immediate superiors. At present no university or ac-

crediting body certifies to their special qualifications, and there is no means for public recognition of their attainments except through membership in one or more of the associations or societies of specialists. At present only two universities, the Universities of Minnesota and Pennsylvania, have well organized opportunities for preparation in clinical fields, including supplementary study in the supporting laboratory sciences and, when the graduates have attained proficiency, recognize it by the granting of advanced degrees. The University of Minnesota gives the degrees of Master of Science and Doctor of Philosophy, modified by the name of the specialty selected. The University of Pennsylvania gives the degrees of Master of Science and Doctor of Science, modified by the words "in Medicine."

2. Short Term Students.—The second group consists of physicians desiring to make further preparation, either in general practice or in some clinical specialty in which they are already engaged. This group includes men and women of all degrees of preparation, from the most meager to the most advanced. They seek opportunities for study, ranging from a few days or a few weeks of intensive instruction to a year of laboratory or clinical experience. To provide courses of instruction, therefore, which they may take without too long an absence from their practice is a most complicated problem. There is a great need for continuation work for both the general practitioner and the specialist, aside from what is obtainable in daily practice and through personal reading, such as the new developments in diagnosis and treatment and the later diagnostic methods and operative procedures.

Too frequently the period that the practitioner can afford to take is so brief that his instructor, who is responsible for the care of patients, does not feel warranted in trusting him with any of that responsibility. Much good, however, is being accomplished by lectures and laboratory courses and clinical demonstrations, however brief. The instruction, therefore, must usually be limited to lectures, demonstrations and laboratory work. When periods of several months can be spent in one field, the instructor may gradually place clinical material at the disposal of the practitioner-student.

CERTIFICATES

A number of institutions grant diploma-like certificates of attendance to practitioner-students for unreasonably short periods of study. Two institutions, indeed, grant such certificates after one week of study. It is fundamentally wrong to grant diplomalike certificates which may be used for wall display to any except those whom the institution knows are proficient in a particular field. It is sometimes urged that these are certificates of attendance only, but the name of the student and the name of the specialty are stated in so conspicuous a manner as quickly to catch the eye of the observer. The public cannot easily distinguish between such a certificate and a diploma in the specialty named: hence they assume that the physician is truly qualified to practice the specialty named. This often false impression is all the more harmful if the certificate bears the name of some well known university or if the name of some special field, as surgery or ophthalmology, is included in the name of the institution, or if it bears the legible signatures of men widely known as specialists in any field of medicine or surgery. Such certificates may readily be, and undoubtedly are, frequently used by unqualified physicians to mislead the public as to their qualifications in the fields named on the certificates.

If a graduate school determines that one of its students is thoroughly competent to practice in any specified field of medicine or surgery, there is no reason why it should not give him a certificate or confer on him an advanced degree. If, however, it does not know that he possesses such competence, it is wrong to grant him a certificate that can be readily displayed on the wall of his office to mislead his patients. Therefore, no diploma-like certificate should be granted to anyone who is not known to be proficient in that field, nor to anyone, under any circumstances, who has not completed at least one academic year in full-time study of a single special subject in the institution granting the certificate. For lesser degrees of proficiency and shorter periods of study, the most that should be granted in the way of a certificate should be a statement in letter form or, better still, on a card that does not contain all the essential data on one side.

These principles should apply also to certificates from hospitals for internships in special fields in which the special field is named. They should not necessarily apply to certificates from hospitals for general internships or resident service in which no special field is named.

PRINCIPLES REGARDING GRADUATE OR POSTGRADUATE MEDICAL SCHOOLS, SCHOOLS OF LABORATORY TECHNIC, AND OTHER INSTITUTIONS PROFESSING TO FURNISH COURSES OF INSTRUCTION FOR GRADUATES IN MEDICINE

The following principles are recommended as a basis for the grading of graduate medical schools by the council.

1. Admission Requirements.—The minimum admission requirement for those wishing to prepare themselves for the practice of a specialty should be graduation from an acceptable (Class A) medical college and completion of at least one year's internship in an approved hospital. In the case of reputable physicians who desire to improve themselves for general practice, lenient admission requirements are justified. Courses for general practitioners should be open to all physicians who have received the degree of Bachelor or Doctor of Medicine from medical colleges considered acceptable by this council, or to reputable physicians who were licensed in certain states before graduation was required.

2. Records.—Records are just as essential in a graduate as in an undergraduate school. Graduate physicians, indeed, will vary more in their preliminary and professional qualifications than the present-day undergraduates, and a knowledge of these qualifications is essential to decide the character and grade of the work to which the graduate student should be assigned. Again, a knowledge of his proficiency in the work to which he is assigned is essential to know whether he is worthy of advancement, or whether he can be trusted with responsibility for the diagnosis and treatment of patients who may be assigned to his care.

Records should be kept by each institution, therefore, showing (a) the preliminary and professional entrance qualifications of every student, which should be verified by authentic or documentary evidence; (b) previous attendance at graduate courses and grades obtained; (c) the subjects for which he is his work; (e) evidence of the student's proficiency enrolled; (d) evidence of his faithful attendance at as demonstrated by his routine or research work, examinations or otherwise, and (f) whether an advanced degree or certificate was granted.

3. Supervision.—There should be careful and intelligent supervision of the entire school by a dean or other executive officer who holds, and has sufficient authority to carry out, fair ideas as determined by the present day needs of graduate medical education.

4. Curriculum and Grading of Instruction Offered.—The graduate school should have its various courses of instruction so graded that the student, if he desires, can obtain progressive work in a continuous course of two or three years, as may be necessary to prepare him satisfactorily for the practice of a chosen specialty. It it is found that at some previous time the student has satisfactorily completed certain portions of the work, he might be given advanced standing and thereby enabled to complete his preparation in a shorter time.

Where short courses are offered in any of the clinical specialties, these also should be so graded that in effect, they would be segments of and, in total, the time and educational equivalent of the longer courses. These segments might be taken at different times, but would ultimately lead the student to the same objective. With the exception of the courses in general medicine, all short courses should fit in with a scheme, the ultimate aim of which would be a complete and satisfactory training in the specialty for which the graduate school provides instruction. Any institution offering work in any specialty, therefore, should provide (a) review courses in anatomy, pathology and the other basic preclinical sciences which apply to the respective specialties; (b) clinics in which students can have the opportunity personally to examine patients in hospital wards and outpatient departments and in which various therapeutic and operative procedures can be demonstrated; (c) courses of operative and laboratory technic; and (d)—to be assigned only when the student's previous training will warrant—assistantships in which, under the supervision of a physician already having recognized skill in the particular specialty, he can gradually assume responsibility in the diagnosis and therapeutic or operative treatment of the sick. Opportunity should be provided also for research work in the chosen specialty bearing on both the fundamental sciences and clinical fields. With courses so graded, no student should be admitted to any advanced short course unless, on careful investigation, he is found to possess the knowledge and skill, such as are obtainable in the other prerequisite courses.

5. Teachers.—In some institutions it was found that courses of instruction were being given by those not qualified either by training or by teaching experience in the subject or subjects to which they were assigned. The general practitioner who can spend only a short period in acquainting himself with the newer things in diagnosis and treatment should receive his instruction from the very best men available. Certainly, their instruction should not be left to recent graduates of inferior schools or others who have not been able to obtain teaching recognition in acceptable medical schools.

The graduate medical school, therefore, should be supplied with a corps of teachers well trained in and responsible for the work in all subjects in which opportunities for study are announced. This should include teachers for essential review or advanced work in the preclinical sciences, as well as those who have in charge work in clinical subjects. The teaching staff should be made up of graduates of or teachers in Class A medical colleges or other high grade educational institutions. The faculty should be organized under the various teaching departments in which work is offered, and a competent teacher should be at the head of each department.

6. Laboratories.—The school should possess well-equipped laboratories to provide proper review or advanced work in both laboratory and clinical subjects essential for the specialty or specialties in which opportunities are offered. There should also be an adequate supply of special apparatus, such as stereopticons, balopticons, photomicrographic outfits and roentgen-ray equipment.

7. Library and Museum Facilities.—All graduate work in medicine demands intensive reading in the field studied. Library facilities in most of the graduate schools are either totally lacking or woefully inadequate. In some instances, however, this lack is provided for by good medical libraries attached to other nearby institutions. The graduate school, therefore, should have a medical library which should include an ample supply of modern text and reference books, files of bound medical periodicals, and the essential indexes. It should also receive regularly thirty or more standard medical periodicals, the latest numbers of which should be on tables or in racks where they are easily accessible to the graduate students.

The school should be supplied with adequate museum facilities, including anatomic and pathologic specimens.

8. Hospitals and Dispensaries.—Graduate courses in clinical subjects cannot be presented profitably in lectures only. There are objections to allowing short term graduate medical students to assume responsibility for the diagnosis and treatment of patients; nevertheless, ample clinical material must be available for demonstrations for short course students and for the personal use of properly qualified students in the longer term. The graduate medical school, therefore, should have a teaching hospital with a daily average of 200 or more patients, and an outpatient clinic with an average of 100 or more patients each day; or, if teaching is limited to a single specialty, a hospital of not less than twenty-five patients daily and an outpatient clinic of at least 50 patients daily. In brief, it should have sufficient clinical material to enable it to provide satisfactory clinical study in the specialty or specialties for which opportunities are offered. In connection with the courses for general practitioners, ample clinical materials should be available so that the student may be given the opportunity personally to examine patients in hospital wards and in the outpatient department, and to make the essential laboratory examinations.

9. Annual Announcements.—The graduate school should publish annually announcements, bulletins or catalogues giving detailed information in regard to its teachers, laboratories, dispensaries and hospitals; outlines of the various opportunities for study offered in both fundamental and clinical branches; a complete list of the students enrolled during the last preceding year, showing their medical schools and years of graduation and the subjects for which they registered, and a list of those to whom advanced degrees or diploma-like certificates were granted.

10. Advanced Degrees, Diplomas, Certificates.—No advanced degree of diploma-like certificate should be granted to any one who is not known to be proficient in the specialty pursued; nor to any one, under any circumstances, who has not completed at least one academic year in full-time study of a single special subject in the institution granting the certificate; and unless scholarship records of the student show that, throughout the period, he has faithfully attended to his work, and unless reasonable tests show that he has diligently and satisfactorily completed the work for which he was registered.

SUMMARY

The following points in the Council's complete report are of particular interest:

MEDICAL EDUCATION

1. Greatly enlarged or entirely new teaching plants have been completed during the last fifteen

years in eleven medical schools and are now under construction or planned for the immediate future in eleven others.

2. The total number of medical students has increased since 1919 at the average rate of 1,162 each year.

3. During the next three years indications are that the numbers of medical graduates will be increased by about 900 each year, reaching 4,500 in 1925.

4. The adoption of higher entrance requirements in medical schools has advanced the average age of students graduating by only three tenths of a year. The average age in 1922 was 26.8, as compared with 26.5 in 1916.

5. In order to establish a better correlation between laboratory and clinical teaching in medical schools, two definite measures are being adopted: (a) Making the curriculum more flexible by omitting detailed requirements, and (b) by erecting new plants whereby hospital and college will be in one building, where laboratories and hospital wards will be in immediate contact.

PROBLEMS OF MEDICAL PRACTICE

The rapid expansion of medical knowledge has brought with it several problems in medical education and practice, including:

1. The Modern Training of General Practitioners.—The training of general practitioners is a matter of special importance, since they should always constitute the great majority of physicians and will be called on to care for patients representing all varieties of diseases and injuries. This is a problem for further study by the council in the early future.

2. The Training of the Specialist.—Part 5 of this report deals in full with this subject.

3. The relationship of the general practitioner to the specialist and the proportion of each type that is needed.—Reliable estimates are that from 80 to 90 per cent of all cases of illness can be properly cared for by well qualified and resourceful general practitioners. While there is a legitimate and important field for properly trained specialists, therefore, the need of them should not be overemphasized. The trouble at the present time is that many physicians are posing as specialists without having first obtained the essential training.

4. The Proportion of Patients that Require Hospitalization.—A reliable estimate states that over 90 per cent of all patients can be cared for efficiently in their homes or in the physicians' offices without the need of the hospital.

5. The Development and Function of Group Practice.—There are at present 270 groups listed with a total staff membership of approximately 2,430 physicians. These groups are divided into (a) the closed hospital group, very few; (b) the one man group, most numerous; (c) the diagnostic group; (d) the co-operative group. (See Part 3 of this report.)

6. The measures by which the benefits of modern medical knowledge and practice can be furnished to the entire public, including the supplying of physicians to rural communities. The best solution at present appears to be for citizens of a community to guarantee a physician an income of $2,500 or more each year for a term of five years. By this measure, it is believed that any community having a sufficient population to support a physician can secure one.

HOSPITALS AND DISPENSARIES

In 1921 there were 6,236 hospitals, sanitariums and homes listed. In the two years since that time about 512 "homes" which did not have hospital departments have been eliminated and the names of about 846 other hospitals have been added, making a total of 6,570 at the present time.

Of the hospitals for intern training, the required number of beds in those eligible for approval has been increased to 100; nevertheless the number of those approved for intern training has been increased from 627 to 654 and provision is made for 3,671 interns.

There are listed 3,294 dispensaries and clinics (excluding group practice) which provide care each year for approximately 8,000,000 patients who during the year make approximately 29,500,000 visits to the dispensaries. An increasing check is being kept regarding the financial status of the patients so that the abuse of medical charity in dispensaries is being held down to a reasonable minimum.

NURSES TRAINING

The suggestion regarding nurse education in the address of the speaker to the house of delegates, May 22, 1922, was referred to the Council on Medical Education and Hospitals. In accordance with the instructions of the house, a special committee was appointed to make a preliminary investigation of the problems of nurse education and to recommend what should be done.

The committee's report shows that the defects in the training schools of today are:

1. The course, on the whole, is unsystematized, unstandardized, and far from uniform.
2. There is too little systematic instruction in practical work and too much theory and certainly a lack of correlation between the two elements.
3. Too many of the teachers are poorly qualified.
4. There is too much of the pupil nurses' time wasted in uneducational routine work.
5. Many schools are connected with hospitals having utterly inadequate facilities.

RECOMMENDATIONS

The committee recommended:

1. That a committee be appointed made up of (a) physicians who are competent clinical teachers; (b) representative nurses, and (c) at least one educator who is neither a physician nor a nurse; that this committee be arranged for by the American Medical Association in conjunction with the National League of Nursing Education, each having equal representation and appointing its own representatives, and that the educator be selected by the other members of the committee when appointed.
2. That this joint committee prepare a standard minimum curriculum for the training of nurses; and
3. That it prepare a classification of nurse training schools in which only those which conform to the standard outlined be considered as acceptable.

THE COUNCIL'S RECOMMENDATIONS

After careful consideration, the council makes the following recommendations:

(1) That the three following named individuals be selected to represent the American Medical Association in dealing with the problems of nurse education and service in co-operation with a similar committee appointed by the National League of Nursing Education:

Chairman, Dr. William Darrach, dean of the Columbia University College of Physicians and Surgeons, New York.

Dr. Winford H. Smith, superintendent of the Johns Hopkins hospital, Baltimore.

Dr. Thomas McCrae, professor of medicine, Jefferson Medical College, Philadelphia.

(2) That in order to bring about the proper correlation of the work with the existing educational and hospital policies, it is recommended that the secretary of the Council on Medical Education and

Hospitals be the secretary of the committee of three, without voting power.

GRADUATE MEDICAL EDUCATION

During the last year an inspection of all graduate medical schools in the United States has been completed by the secretary of the council and Dr. Louis B. Wilson of the Mayo Foundation.

From the data obtained in this investigation, a series of principles has been prepared as a basis for a proposed classification of the various graduate medical schools.

CLASSIFICATION OF GRADUATE MEDICAL SCHOOLS

Based on the foregoing principles, the following classification of graduate medical schools is recommended:

Class A.—Those which have adequate equipment, which are furnishing acceptable and complete graduate courses of instruction in one or more specialties and which grant advanced degrees or diploma-like certificates only to students who are properly qualified.

Class B.—Those which (a) are seriously deficient in certain respects, or (b) which have ample equipment and offer acceptable courses, but which grant advanced degrees or diploma-like certificates to students who are not properly qualified.

Class C.—Those which (a) do not have adequate equipment or teaching facilities, or (b) are not properly organized, or (c) do not adhere to the prescribed educational standards, or (d) offer courses in a specialty too brief or inferior to insure proper qualifications in the specialty, or (e) grant advanced degrees or diploma-like certificates to those not properly qualified.

Respectfully submitted.

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Arthur D. Bevan, Chairman.
Merritte W. Ireland.
Ray Lyman Wilbur.
Samuel W. Welch.
William Pepper.
N. P. Colwell, Secretary.

State News Notes

COLLECTIONS

Physicians' Bills and Hospital Accounts collected anywhere in Michigan. H. C. VanAken, Lawyer. 309 Post Building, Battle Creek, Michigan. Reference any Bank in Battle Creek.

$10,000 Practice (with minor surgery) for sale at Lake Orion, 35 miles from Detroit. 7-room modern home with offices attached and garage. $8,500. Terms. Dr. A. M. Watson, Deroit, Mich., 8786 Linwood.

WANTED—Assistant surgeon, full time service. Must be a single man. Write for details to H. A. Grube, chief surgeon, Michigan Soldiers' Home, Grand Rapids, Mich.

Dr. and Mrs. Max Ballin of Detroit sailed early in July to spend the summer in Europe.

Dr. and Mrs. Duncan Campbell of Detroit spent the month of August on Cape Cod.

Dr. and Mrs. E. W. Haass of Detroit are spending the summer in Europe.

Dr. R. J. Hutchinson, Grand Rapids, is at his camp in Northern Canada, returning September 1st.

The Upper Peninsula Medical Society held its annual meeting August 22 and 23, at Iron Mountain.

Dr. T. D. Gordon, Grand Rapids, departed for Europe, July 15, for six months' study.

Born to Dr. and Mrs. B. C. Corbus of Grand Rapids, the latter part of June, a daughter, Harriette Jane.

Dr. Max Ballin of Detroit spoke on "Spinal Cord Tumors" before the Academy of Medicine of Toledo, May 25, 1923.

The Seventh Annual Scientific Session of the Association for the Study of Internal Secretions was held in San Francisco, June 25, 1923.

Dr. V. C. Vaughan gave an address on "The Future of Medicine" before the Milwaukee Academy of Medicine, June 12, 1923.

Dr. William LeFevre, son of Dr. and Mrs. George LeFevre of Muskegon, is taking his interne year in the Memorial Hospital, Philadelphia.

Governor Small has signed the bill appropriating $403,000 to establish a medical research laboratory at the University of Illinois.

Dr. Guy L. Kiefer of Detroit joined Mrs. Kiefer at their summer home at Mackinaw Point, August 1, 1923. The Doctor will be away one month.

Dr. B. D. Harrison left Detroit August 1, 1923, to join his wife and daughter at their summer cottage on Steere Island, Sault Ste. Marie.

Dr. Harry N. Torrey of Detroit with three other men sailed July 28, 1923 for Africa for five months of exploring and hunting big game.

Dr. C. T. Southworth's son is taking his internship in the Northern Pacific R. R. Hospital in Tacoma, Washington.

Miss Ruth MacLachlan, daughter of Dr. and Mrs. Daniel MacLachlan of Detroit, was married June 29, 1923, to Mr. Lee Richardson of Alpena.

Dr. G. W. Stockwell of Detroit sailed for Europe the later part of June. He will return the first part of September.

Mr. John D. Rockefeller, Jr., recently gave the University of Michigan $10,000 to cover the cost of treating diabetic persons with insulin.

Miss Dorothy Yates, daughter of Dr. and Mrs. H. W. Yates of Detroit was married, June 26, 1923, to Mr. Sidney B. Coate of Grand Rapids.

Dr. and Mrs. L. J. Hirschman left Detroit the early part of June for a three months trip through Europe.

Dr. W. J. Seymour of Detroit has been appointed a member of the Welfare Commission. He succeeds Dr. Max Ballin (resigned).

The University of Michigan conferred the degree of Doctor of Science on Dr. George E. de Schweinitz of Philadelphia, June 18, 1923.

Dr. Clemens Pirquet, Professor of Pediatrics in the University of Vienna, Austria, has been ap-

pointed Professor of Pediatrics at the University of Minnesota.

On June 21, 1923 Dr. William W. Keen of Philadelphia completed 50 years as a member of the Board of Trustees of Brown University, Providence, R. I.

Dr. R. E. Mercer has resigned as Professor of Physical Diagnosis in the Detroit College of Medicine. He has been spending his winters in the west.

Dr. George W. Crile of Cleveland was elected President of the American Surgical Association at the annual meeting, held in Rochester, Minn., May 31-June 2, 1923.

Dr. W. T. Dodge of Big Rapids attended the American Medical meeting in San Francisco and spent a month visiting and touring the western states and national parks.

Dr. and Mrs. Joseph E. G. Waddington of Detroit will sail August 25th to spend three months in Central Europe. While abroad, the doctor will attend clinics in Copenhagen, Berlin, Vienna, Leyden and London.

Dr. Charles D. Aaron of Detroit read a paper on "The Futility of Surgical Intervention in the Treatment of Gastro-Enteroptosis" before the American Therapeutic Society, in San Francisco, June 23, 1923.

Dr. W. P. Manton has resigned as Professor of Obstetrics in the Detroit College of Medicine. The Doctor has bought a home in California. Dr. Manton has been appointed Emeritus Professor of Obstetrics in the college.

Dr. R. C. Jamieson has been appointed Professor of Dermatology in the Detroit College of Medicine succeeding Dr. H. R. Varney (resigned). Dr. Varney has been appointed Emeritus Professor of Dermatology.

At the 79th Annual Meeting of the American Psychiatric Association, held in Detroit, June, 1923, the following officers were elected: President, Dr. T. W. Salmon of Larchmont, N. Y.; Vice-President, Dr. W. A. White of Washington, D. C.; Sec'y Treas., Dr. C. F. Haviland of Albany, N. Y.

A tract of 44 acres of land in Minneapolis (valued at $100,000) and an endowment fund of $900,000 have been given to the University of Minnesota for the construction and endowment of a hospital and convalescent home for crippled children.

At the Ann Arbor examination, held June 5-7, 1923, by the Michigan State Board of Registration in Medicine, 177 persons took the primary examination and 131 the final. At the Detroit examination, held June 11-13, 1923, 74 took the primary, 51 the final examinations, 8 took the drugless and 3 the chiropody examinations.

Dr. H. K. Shawan has recently been appointed Professor and Head of the Department of Surgery in the Detroit College of Medicine. He takes the place of Dr. Angus McLean who resigned to become a member of the Detroit Board of Education. Dr. McLean has been appointed Emeritus Professor of Surgery.

A bequest of $5,000 to Dr. Don M. Campbell of Detroit for the study and treatment of eye, ear, nose and throat diseases was announced June 14, 1923, following the filling for probate of the will of Mrs. Ellen M. Chipman. This study can be made in any hospital that Dr. Campbell may designate.

According to reports, Joseph Synowski, infant plaintiff in the $50,000 damage suit against James and Margaret Connell, chiropractors in Jackson, for alleged malpractice, was awarded, May 25, 1923, judgment for $7,000 in the circuit court.

Dr. Harold L. Morris of Detroit read a paper June 27 before the Urological Section of the American Medican Association at San Francisco, entitled, "A Study of the Chemical Solvents Used in Dissolving Foreign Bodies in the Urinary Bladder, Such as Paraffin, Beeswax, Gum and Urethral Pencils."

Dr. A. R. Moon has recently moved from Detroit to 117 South Webster street, Saginaw, where he expects to continue the practice of obstetrics and gynecology. Dr. Moon has resigned from the positions which he formerly held in Detroit as junior obstetrician, Harper hospital, and as president of the medical staff, Florence Crittenton home.

The National Board of Medical Examiners changed (November, 1922) the title of those who hold its certificates from licentiate to diplomate. This certificate of the National Board is, strictly speaking, just such a credential. It is in no sense a license to practice medicine. Boards of 24 states have given their approval and recognition to the National Board's certificate. The rest of the states, to date, have not.

Haslett, a village of about 300 people, ten miles north of Lansing, and college, is without a physician. It is well located on main line of Grand Trunk railroad and interurban railroad (M. U. R.) They asked me to write you to send them a physician if you had any enquiries. Further information can be had from Henry Behrendt, former marshall of Eastern Michigan District, who lives at Haslett. Sincerely, A. M. Campbell.

County Society News

HOUGHTON COUNTY

The Editor of the Journal of the Michigan State Medical Society:

The regular meeting of the Houghton County Medical Society was held at the Lake Linden hospital, June 4, 1923.

Dr. P. D. Bourland presented a paper on "Encephalitis," and dwelt upon its diagnosis in the milder form, especially the cell count and sugar content of the spinal fluid; also as an etiological factor in a later Parkinson's disease.

Dr. H. A. Mauthei presented several cases of Parkinson's disease, multiple sclerosis, and primary lateral sclerosis, and also dwelt on their early diagnosis.

There are at present in Lake Linden and vicinity some seven cases of Parkinson's disease.

We had a very interesting discussion among the 20 physicians present and a delicious luncheon was served by the nurses of the hospital.

Dr. John Moore will entertain the Medical Society in July at his bungalow on Portage Lake.

The staff of the Memorial hospital in Laurium will give the Society a clinic in August.

Very truly yours,

Charles E. Rowe, Secretary.

LAPEER COUNTY

The Editor of the Journal of the Michigan State Medical Society:

At the meeting of the Lapeer County Medical Sosociety, held June 19, 1923, the following resolution was adopted.

Resolved, That it be the desire of the Lapeer County Medical Society that Dr. S. A. Snow of North Branch, Mich., become an honorary member of the State Medical Society; and further

Resolved, That the Secretary transmit a copy of this resolution to the councillor of this district.

Fraternally,

D. W. Crankshaw, Secretary.

WAYNE COUNTY

REPORT OF PUBLIC HEALTH COMMITTEE

The work of the Public Health Committee of our Society during this year has been along four lines:

1. (a) To act as an intermediary between our Medical Society and the Detroit Department of Health in matters of policy; (b) as an agency to harmonize the activities of each especially in relation to venereal diseases; (c) as a line of communication for furthering co-operation between the Medical Society and the Department of Health in connection with preventive medicine in other than venereal diseases.

2. The Public Health Committee has undertaken the investigation of certain reported practices in clinics and hospitals which were understood by the complainants to restrict the working field of private practitioners, namely, the performance of an amount of free and charity work out of proportion to the number of destitute or indigent people to be found in our community and entirely beyond its needs.

3. The Public Health Committee has engaged in the development of a Health Exposition to be held this year under the auspices of the Wayne County Medical Society.

4. Miscellaneous activities, including (a) a meeting with officials and representatives of the Michigan Chiropodist Association; (b) an attempt to keep posted at the Wayne County Medical Society Building such information concerning current operation, conference, and clinical meeting schedules of the various local hospitals, (c) and such matters as furnishing to the United States Public Health Service our opinions on the incidence of venereal diseases, etc.

The operations of this Committee in connection with the above outline will be considered seriatim.

WAYNE COUNTY MEDICAL SOCIETY AND DETROIT DEPARTMENT OF HEALTH

1. During the present year, as in previous years, there have been received by this Committee a number of communications from members of our Society detailing incidents that were interpreted as acts of unprofessional conduct on the part of Department of Health employes; others which indicated that some employes of the same department had belittled the work of the private practitioner and had jeopardized the patient's and his family's respect for the attending physician. However, judging from the small number of such complaints received, it appears that the Department of Health nurses have exercised greater caution in their relations with the public and our profession. We are informed and believe that each of such complaining communications receives the proper investigation to the end that such occurrances shall be prevented. The rules of the department are very exacting in this respect, and your committee feels that the officials do not tolerate indiscretions as are reported from time to time.

"To err is human," and, knowing the facility with which even our own members may cause offense by being over-zealous in their duties, it is understandable how the Department of Health employes may occasionally arouse the ire of the physician and the public. In order that such incidents may be reduced to the lowest possible limit, it is advised by this Committee that physicians enter complaint only with complete details concerning the nature of the case, date, name and address of patient, name of employe, and pertinent facts.

Any member of this Society who believes the facts warrant an objection on his part should manifest sufficient interest in his own affairs and in the welfare of the other members of this Society to provide full details without putting such burden upon members of a committee. With the facts at hand these matters can and will be adjusted. It is again urged that trespassing upon our rights can best be controlled by the active interest of each of our members, immediate investigation, and full and detailed report to this committee. At no time has the Health Department indicated an unwillingness to co-operate with us toward the abolishing of this evil.

2. That the activities of the Wayne County Medical Society and the Department of Health may be harmonized and to co-operate directly with the department in the conduct of its venereal disease clinic, the following subcommittee was appointed by your chairman on the invitation of the Commissioner, Dr. Henry F. Vaughan: Dr. Wm. E. Keane, chairman, and Dr. Robert Rosen, secretary. The secretary's report follows:

January 17, 1923.

Dr. R. A. C. Wollenberg, Chairman,
Public Health Committee,
Detroit, Michigan.

In accordance with your request we have visited the venereal clinic of the Board of Health, and present to you the following report:

The clinic has moved and is now located on the third floor of the City Service Building on Clinton street. We beg to report that the social service investigator, whose duty it is to check up as far as possible the statements of the individual cases as regards the economic and financial condition, is all that we could expect from one individual. He should be given more power and help. In going over the records with him we find that from February 13, 1922, to January 13, 1923, Mr. Snook interviewed 4,581 cases as to their economic and financial condition. Of these 1,128 were married; 3,078 were single: 103 widowed; 272 divorced; 2,710 were employed; 1,871 were unemployed; 3,466 were white, 1,115 were colored. Of these 1,886 were treated for syphilis, 2,791 were treated for gonorrhea, 78 miscellaneous, 13 referred to clinics, and 951 referred to physicians. These 951 were in a position to pay a private doctor for medical attention. Admitted to the clinic for treatment were 3,617.

It seemed to us that there should be a department for men similar to the one conducted for delinquent women, where men who refuse to take treatment from a private physician should be enforced to remain there by the police and treated. Only in this way would these social pests and menace to society be taken care of. It seems to us only fair to treat both sexes alike in this respect.

We state again that we feel that every effort is

being made to determine whether an infected individual is able to pay a private physician, and, where this is possible, treatment is denied at the clinic. If police enforcement were possible as suggested herein, these men would take treatment more readily.

We would recommend that Mr. Snook be allowed this police power and additional social service help. In this way this problem could be handled more efficiently.

(Signed) Robert Rosen.

It is concluded from the above report that the Department of Health restrictions placed about female delinquents affected with venereal disease meet with the approval of this subcommittee, but that our community is not sufficiently protected against males in the same station and similarly diseased; also, that the social service work in the venereal disease clinic is found to be inadequate.

In connection with venereal disease, this committee cannot ignore the fact that instances of gouging and unfair dealing on the part of members of our profession have been discovered. To charge a workingman from $25.00 to $50.00 for 1 salvarsan injection and to capitalize the fear of a young unfortunate have been known to blast his hopes, to ruin his finances, and to lessen his prospects of recovery of both health and morals.

We urge physicians to plan carefully the treatment of their luetic patients. Early and satisfactory treatment should not be so burdensome financially that patients will be unable to complete the courses. Early and contniuous treatment should be provided in order to prevent infection of others and that tertiary symptoms may not develop in later life to cause further public burdens.

3. This committee studied with the Department of Health a number of problems of mutual interest.

On account of the existence of a state law, Public Acts 274, 1919, which prohibits compulsory physical examination or compulsory treatment of school children, it is found that the use of such disease preventatives as vaccination and diphtheria toxin-antitoxin cannot be actually enforced, and their broad use depends largely upon the attitude of the public. Members of the medical profession by their daily and direct contact with the public should exert a constant educational influence.

The world is full of opportunity and work for the physician who is active and alive to his medical obligations, and there is no one else to blame for any opprobrium that attaches itself to the high incidence of these two diseases in particular, not to forget that yphoid fever is now practically preventable by prophylactic vaccine injections. In connection with these and other diseases, the following resolutions have been adopted:

A. "In view of the prevalence of deaths from diphtheria in this city in the age group of 6 years and under, it is urged that physicians make use of prophylactic measures, namely, toxin-antitoxin in the immunization of young children of 1 years old and above who are in their clientele."

B. "On account of the greater efficiency of the early administration of diphtheria antitoxin, physicians are urged to treat all clinical cases of diphtheria with antitoxin without waiting for corroborative laboratory evidence. USE ANTITOXIN EARLY."

C. "In view of the comparatively rare occurrence of cases of smallpox in the practice of physicians, it is urged that whenever a physician may be in doubt regarding the diagnosis, the patient be placed in isolation and a consultant be employed if finances permit; or, if not, that the consulting service of the Department of Health be sought in connection therewith. If this practice is carried out it is believed that extensive exposures to mild cases of smallpox will be avoided."

D. "Typhoid fever is now a comparatively rare disease. Whenever a physician sees a patient who may have typhoid fever or para-typhoid fever, the physician is urged to make use of laboratory procedures which will assist in making a correct diagnosis. If the patient is within the first week of the disease a blood culture will be of assistance, and after the ninth day of Widal test may be useful; repeat if the clinical symptoms demand. Of course, blood counts and differential examination of white cells may be useful. For a patient who is unable to pay for this examination the service of the public health laboratory is at your disposal. Care in the matter of diagnosis will not only be of service to the patient, but will be useful to the local health authorities in detecting the onset of an outbreak of typhoid fever and in some instances may remove from a community the stigma which may be imposed through carelessness in this regard."

E. "In the examination and in the care of cases of tuberculosis, physicians are urged to instruct the patient in the proper disposal of tuberculous discharges, and the association of young children with open cases of tuberculosis should be avoided as much as possible. Again, physical examinations of all contracts should be made for incipient tuberculosis. Minute instructions as to rest and food should be given the patient. Patients who cannot pay for examination of sputum should have the material sent to the Department of Health laboratories. Culture stations are equipped with sputum outfits. Where X-ray examination is required, if the patient cannot pay for such service, the physician may take the patient to the Department of Health for such examination. A patient who cannot afford a physician may be referred to the Department of Health tuberculosis clinics."

F. "PROMPT reporting of all cases of communicable diseases to the local health department is urged upon physicians. It is a requirement of the law, a service to the public, and a courtesy to other members of the medical profession."

G. "On account of the fact that the transportation facilities in Michigan are so easy, circulation of the people over wide areas is very extensive, and it would appear that uniform health regulations throughout the state would be of general public interest and demand. Since it would be a proper function of the State Department of Health it is the belief of this committee that an adequate organization should be formed and be under the general supervision of the State Health Department, whose object it would be to co-ordinate the health regulations of various localities, and this recommendation is referred to the legislative committee of this Society for its consideration."

H. "The Visiting Nurses' Association is commended for the nursing service which they make available to the community, and it is urged that its service be extended to include, where necessary, the care of patients affected with communicable diseases."

CHARITY WORK IN DETROIT HOSPITALS AND DETROIT DEPARTMENT OF HEALTH

Your Public Health Committee has engaged in the investigation of certain reported practices in Detroit hospitals and the clinics of the Department of Health which appear to restrict the working field of the private practitioner. Letters received and opinions expressed in interviews by some of our Society members indicate that some clinics are doing an unwarranted amount of free work, or work for a very nominal fee, on patients who are fully

able to pay reasonable fees; that clinics have wilfully permitted their abuse by calloused and habitual visitors whose motto may be, "Why pay when you can get something for nothing." The question has arisen whether such hospitals are placidly furthering and promoting a contempt which some patients of means may have for the man in private practice and are permitting the latter to be euchered out of many patients who have no right whatsoever to be recipients of charity from our profession.

To be permitted through charity to relieve the suffering of the poor is one of our greatest privileges. Many of us shall advance no other plea at St. Peter's gates than that we have healed and given succor to the poor and unfortunate. However, it is quite another matter to have our profession exploited.

There are about 35 hospitals in the city of Detroit. To each of these your chairman addressed a letter of which the following are two paragraphs:

"A number of members of the Wayne County Medical Society have been impressed with the large amount of free work that is being done at the various hospital clinics, having in mind especially the large number of tonsil operations and venereal cases. It is the belief that a certain portion of these cases are in patients who could well afford to pay a physician in private practice a fair charge for such work. This matter has been very thoroughly discussed from various angles by members of the Public Health Committee, and by vote of its members a committee was appointed to investigate the situation as one of interest to the entire Society."

"The committee consists of Dr. J. E. Bernstein and Dr. Chester A. Doty. We ask your kind cooperation, assistance and permission for this committee to call upon you to get such information as will assist us in forming conclusions in regard to the situation in question."

To these letters, which were repeated after two weeks, but four replied: Grace hospital, Receiving hospital, Herman Kiefer hospital, and the Henry Ford hospital.

Dr. W. L. Babcock of Grace hospital offered his records to the committee. Dr. T. K. Gruber of the Receiving hospital stated in part as follows: "Will say that we will be very glad to co-operate. It has always been my contention that the medical organization in every city has been remiss in its duties. A large number of members stand around and do a lot of talking about charity work that is being done, but they never do anything more about it. The whole proposition could very easily be brought to a head and taken care of very satisfactorily if an organization like the Wayne County Medical Society would get behind it. All the facilities of this institution are at the service of your committee to make whatever investigation is within reason."

No charity work such as we have in mind was stated to be done at either of the other two institutions.

Your committee feels that some members of this Society representing the other 30 odd hospitals had shown this committee and the Society no consideration or courtesy whatsoever. The reason? Either inertia or that it was considered to be none of your business. However, the members of the subcommittee each submitted a report for which each is individually responsible and which each is prepared to discuss.

Dr. E. J. Bernstein's report:

THE DISPENSARY ABUSE IN DETROIT

Up to five years ago Detroit was a favored city in that it had no concern in the question of dispensary abuse. It, however, began to manifest itself during the war when many heads of families were drafted into the army. Since the marked depression incident to the days of socalled readjustment, notably since the fall of 1920, when everyone felt the pinch of hard times, when those hitherto in comfortable circumstances, to say nothing of the thousands of workmen who were out of employment, either totally or partially, felt the pinch of poverty and were forced to accept aid, not alone in times of illness, but even to get food and raiment to put on, this dispensary abuse has grown by leaps and bounds and is not only pauperizing a self-respecting public, but it threatens to engulf the medical profession. The only exceptions to this calamitous state of affairs in the profession are those doctors whose practice is among the well-to-do or those people who are too self-respecting to accept charity. Added to this evil in our midst, is the old problem of the evil done to the profession by the university clinics at Ann Arbor, plus the inroads of the public health boards and the dread of state medicine.

Those of us who have practiced medicine for a score or more years, and especially those who started their careers in the large cities of the east, know of the starving remuneration of the first 10 or 15 years of practice, when $200.00 was all a young doctor might except to earn in the first year. If at the end of 10 years he had a $1,500 practice, he was quite satisfied. We are rapidly returning to that state, unless the profession of the city looks after it own salvation as thoroughly as the health board officers and hospital authorities take care of themselves. That this is not a figment of an excited imagination, one need only visit the clinics of the city, and, certainly if one will go to any of the large clinics in Chicago, New York, Philadelphia, Boston or Baltimore, he will find the reason for the many papers on dispensary abuse which have from time to time appeared in the medical literature.

There is no profession or body of men so willing to work for the public good, without pay, so lacking in self-interest, as the doctor's. We are the easy mark of every well-intentioned but often misguided reformer or uplifter who invades, unopposed, the practice of medicine and surgery until the time has arrived for raising the danger signal. Now what are the facts that confront us here? The Welfare Bureau of this city says the minimum wage on which a family of father, mother and three dependent children can exist is 12 times $142.00, or $1,704.00 a year and put aside $10.00 a month for illness and unlooked for contingencies. From the board of commerce I learn that the average wage of the industrial worker here is $5.30 per day, or $1,537.00 per year (290 days making the maximum number of working days per year).

(These wage figures are considered high by the Federation of Labor).

In Detroit proper, the wage is	$4.89
In Hamtramck the wage is	5.14
In Highland Park the wage is	5.91

This schedule is made as follows:

88,773	skilled laborers at	$6.36
6,535	foremen at	7.40
1,251	superintendents at	10.48
2,563	salesmen at	8.21
78,819	unskilled workers at	4.89
52	women superintendents at	4.59
514	forewomen at	4.07
28,563	women over 16 at	3.05

These figures represent the allied industries affiliated with the board of commerce, and their statistician says that 50 per cent more workers is about the total so employed in and about Detroit. The number so engaged has gradually increased from

65,000 employed in the fall and summer of 1921 to 250,000 on the daily payroll from April 1st to November 8th, 1922.

This does not account for the men in the building trades, or other trades, and the small storekeeper. This means that this great army of workers is being underpaid by the manufacturers, and in sickness the doctor is expected to supply the deficiency of pay by donating his services gratis. The board of health feels that any single man making less than $90.00 a month, or any married man with less than $125.00 a month, is a proper subject for medical charity. If this were half way looked after, there would be no cause for questions, and the attendance of the clinics would not assume such vast proportions as they do. There is a certain amount of investigation, which, taking the statements of the hospital superintendent and Board of Health at par, is sufficiently done. We know, however, that the vast majority are taken without the faintest pretense of weeding out the unworthy. Take the matter of free tonsil work done. One of the hospitals in the city has been doing from 10 to 20 a day for a year or so, during that time, the number of paid cases ranged from one to four. The Receiving hospital claims that it does but 25 free tonsillectomies a month. Harper claims it does three or four a day, but attempts to find out how many they care for at from $3.50 to $15.00 have failed, though I have been to see the various persons in charge.

The semi-free treatment of the public is possibly the greatest evil, for it establishes in the minds of certain types that $15.00 is the maximum fee to pay for hospital care and operation. The hospitals lose nothing, for the superintendent of the Receiving hospital tells me that the city pays for the hospital care of all free cases.

One hospital does from 10 to 20 cases daily. Out of the total number of patients visiting the clinic for all care, 71 house investigations were made in one month, some cases were eliminated at the desk: about 50 cases paid small fees to the staff, ranging from $2.50 to $25.00. Altogether $312.00 was thus paid to members of the dispensary staff.

It is very evident that the profession in Detroit is up against a very real thing. We are rapidly drifting into conditions present all over Europe and in the large cities of the east.

An increasing number of public hospitals and charitable institutions under governmental control and support, health centers, diagnostic clinics, diagnostic clinics, health insurances, compensation acts, and insurance hospitals where employers, for a nominal sum, can send their employes to be treated by a few underpaid doctors who handle a large number of patients daily at a cost of about 10 cents a patient, are threatening the livelihood of the doctor.

No one man can buck the management of the hospitals whose large buildings must be kept full. The greater activity in the way of large clinics and full beds they show, the more secure is the position of the head of these institutions.

There can be no such thing as free dispensaries and free clinics—they are bought and paid for by every member of the community and the doctor is doubly taxes; first, as a member of the community, and secondly, by competing with and destroying his means of livelihood. At the same time the community is being pauperized. Taxpayers have a right to protest against paying the medical bills of those financially able to pay their own expenses. It is making liars and cheats of people.

SOLUTION OF THE PROBLEM

The solution of this problem may be stated under three heads:

1. There should be a social service ably trained to make real and thorough investigations and be competent to distinguish between the needy and those possessing the ability to pay.

2. There should be an awakening of the medical profession to the realization that it is equally responsible for this pauperization. There should be censorship of the services of the physician by some responsible body like the county medical society, as has been done in connection with contract practice, so that patients able to pay, should not be cared for gratuitously.

3. There should be education of the public to an understanding that if the standards of medicine are lowered through the loss of impetus and initiative in the young physician, the public will be the chief sufferer.

4. There should be formed here in Detroit an organization on the lines of that in Buffalo by the medical profession to look after our interests as to clinics, state, medical, etc.

(Signed) Edward J. Bernstein.

January 17, -923.

Dr. Chester A. Doty reports as follows:

PRELIMINARY REPORT

January 17, 1923.

Dr. R. C. Wollenberg,
Chairman of Wayne County Public Health Committee.

Dear Sir:—

I desire to submit a preliminary report covering partially the investigation in the branch of dermatology and syphilis in the various free clinics which care for the indigent poor, as follows:

Highland Park General Hospital—

The clinic is small at this hospital, and there is a very efficient social service worker, Miss Bell. This clinic is well investigated and contains few, if any, that are other than needy.

Receiving Hospital—

This clinic is very well handled. The heartiest co-operation was extended to our committee by Superintendent Dr. Gruber. In every way his work is to be recommended.

Grace Hospital—

At Grace hospital we were informed that in syphilis and venereal diseases the clinic was small, by the superintendent. We found that this clinic handles a fairly large number.

Board of Health—

This is the largest clinic in the city. Patients are all received upon entering, and after diagnosis they are referred. Upon this point I desire to call your attention. First, if a patient enters with an apparent primary lesion the dark field and Wassermann are given. If negative he is retained and Wassermanns given each week, also dark field. If they continue to be negative the lesion is treated with Cu So 4. Diagnosis is often not made in from 4 to 10 weeks. A considerable number of these patients are single, earning from $4.50 to $7.50 per day, many holding good positions. Should they be kept under observation for this time free of charge? *Why should they not be referred to a private physician for diagnosis?

The investigation is much in question. The patient comes in with his story; he is questioned and rejected or admitted, depending on the judgment of one man. No checking up of this is instituted except possibly in rare cases. The story of the patient is the basis of acceptance or rejection in most cases. The examination is preliminary requiring about 10 minutes on the average.

This report covers only a part of my work at this

time, the remainder of which will appear in the final report.

(Signed) Chester A. Doty.

*Dr. F. Meader states: "The number of cases of this kind average about one per week. The patient cannot be made to get under treatment because th diagnosis of syphilis has not been made. The Health Department does this to protect the public."

Final report of Mr. Doty.

April 19, 1923.

Mr. Chairman:—

In my previous report a number of points were covered relative to the conditions in the clinics of the various hospitals. The so-called free clinics such as we were requested to investigate, do not exist. Practically all of the clinics, except the Receiving hospital, have certain set charges for calls and various operations. Many of the hospitals have a large crop of social workers, stenographers and nurses, in which cases it would seem the co-operation supposed to exist between the profession and the clinic is lost, due to the fact that expenses are high, and this necessarily requires a large clinic to assist in defraying the same. This refers to the pay clinics which receive part of their support from the Detroit Community Fund; consequently, it would seem that the main object in mind is to keep the clinic large, regardless of the patient's financial status.

Referring to the Board of Health, it has a large clinic. It gave last year over 11,000 salvarsans. The lack of investigation relative to their being indigent cases is the main point of criticism. One investigator is compelled to determine by means of verbal examination the financial status of each patient. This method is inadequate. As a result a plausible story is concocted, passed on by word of mouth from one to another patient, and is accepted provided the story is not found contradictory by the investigator.

If, in the opinion of the investigator, this patient seems able to pay a physician's fee, he is given the names of physicians, provided he has no choice of his own. There is no doubt but that many patients are receiving venereal treatments who would be able to pay a reasonable fee to the physician. In an investigation covering three days I found what appeared to me to be questionable cases to the number of about 75, all of which appeared to have enough money to be able to pay a physician for treatment. These should be carefully checked up. Their incomes and habits should be more carefully studied to determine finally whether they should be cared for at public expense or if they should be left to their own devices and be trusted to take treatment from a private physician.

The physician is also at fault to quite an extent in that he does not in these cases analyze the patient's financial condition and accepts a nominal fee rather than to have him go away in an antagonistic frame of mind and report to the Board of Health.

The next point is the charge made by the Board of Health. This institution charges $2.00 for each salvarsan. Should a patient be an indigent case when he first applies for treatment at the Board of Health and later on secures a position enabling him to again return to a physician after paying a $2.00 fee, the patient reasons that all charges above $2.00 are so much personal profit for the doctor and are excessive, leaving him in a frame of mind that the private doctor's charges are exorbitant and causing a lack of faith in the profession.

It does not seem reasonable that so large a number of cases receiving treatment should be public charges, nor that there is such an excess of venereal cases among the indigent poor. By taxpayers the Board of Health was instituted to assist the physician to practice preventive medicine rather than curative medicine.

It is plainly evident that by the present system of charging, the health board veneral clinic is competing with the private physician in practicing curative medicine and unintentionally injures the patient's respect for the doctor in the field, who, by the way, is one of the taxpayers who supports the department.

I recommend the discontinuance of any charges by this institution; either pay a reasonable fee to the private physician or pay nothing at the clinic; also more complete investigation of the financial condition of venereal cases.

In many of the industrial plants the medical work is handled through insurance companies. These companies have in all cases curtailed expenses and in many cases part of the medical work is handled by first-aid men, nurses, etc. In these instances very often the employe has made the mistake of thinking that the medical aid was being given him by a physician. It would seem advisable that medical treatment be given only by physicians for the protection of the workers.

Respectfully submitted,

(Signed) Chester A. Doty.

Dr. F. Meader of the Health Department and a member of the committee gave us interesting facts concerning the presence of venereal disease. He stated that about 10,000 cases of venereal disease were reported from Detroit in 1922. Of these 4,000 were reported from the Health Department, of which, in round numbers, 1,110 were sent to private physicians for treatment; 70 per cent of these referred cases get to the physician; 30 per cent apparently leave the city or go to physicians of whom we know nothing.

Mr. Meader's following letter concerning tonsillectomies explains itself:

Dr. R. A. C. Wollenberg,
938 David Whitney Building,
Detroit, Michigan.

Dear Dr. Wollenberg:—

Your letter of October 26th to the Board of Health relative to tonsillectomies, has been referred to me for reply. I will, therefore, take up the questions you presented in the order in which they are given:

1. Who and what departments refer children to hospitals for diagnosis or for treatment of throat conditions? In reply I would state that the division of school medical inspection and also the division of tuberculosis refer cases where indications so warrant.

2. Who eventually decides whether tonsillectomy shall be performed? In reply to this I would state that the physician in charge of the eye, ear, nose and throat clinic recommended 719 children for corrections which would involve removal of tonsils and adenoids during the past year. The physician on duty at the tuberculosis clinic made similar recommendations in about 50 cases during the last year.

Last year the physicians in the division of school inspection recommended 21,672 children receive attention to throat conditions as per the attached slip.

DETROIT DEPARTMENT OF HEALTH
—RECOMMENDATION SLIP

Name ..... Date.....
Address ..... Age.....

TO THE PARENTS: In the routine physical inspection of school children by the medical inspectors of the Health Department, there were found on the date above indicated certain conditions with respect to .....

which it would be worth while to look into more carefully. These conditions may be temporary and of no significance. The examination that we have made was of necessity a rather hurried one and should not be considered absolutely final. However, these conditions may be of a permanent nature which for the best interest of your child should be corrected at this time. We advise that you consult your family physician, who, being more familiar with the previous history, will be better able to decide what corrective action, if any, should be taken.

School .....
Room .....
Grade .....

Medical Inspector.....
Sch. 442.

These children then go to their family physician or to the nearest hospital for further examinations and decision relative to their throat condition. Our records show that during the last year there were 6,377 corrections for tonsils and 4,945 corrections for adenoids performed on school children.

3. Upon what indications is it decided definitely that a tonsillectomy shall be performed? In reply I would state that the following are the rules adopted by the Board of Health as indicating or contra-indicating tonsillectomy:

Rules adopted by the Board of Health for the guidance of its physicians on the advisability of Tonsillectomy:

(These rules have been adopted after consultation with leading specialists in the city, and from a review of literature upon this subject.)

INDICATIONS

1. When there are obstructive symptoms—mouth breathing, difficulty in breathing through the nose, difficulty in swallowing, with or without evidence of high arched palate, or a persistent nasal discharge, tonsillectomy and adenectomy should be recommended.

2. If the frequent occurrence of tonsilitis has produced definite disease in the tonsils as evidenced by irregularity, raggedness and friability, or a recurrence of cheesy material in the crypts giving a foul odor to the patient's breath, or when the patient has symptoms of toxic absorption; for example, malaise, myalgia, anorexia, anemia, etc., tonsillectomy is indicated.

3. In case of persistent cervical adenitis following tonsilitis, whether pyogenic or tuberculous origin, tonsillectomy is indicated.

4. When there is a discharge from the ear or impairment of hearing which has appeared following an enlargement or definite pathological changes in tonsils or adenoids, the removal of tonsils and adenoids is indicated.

5. A patient suffering from a repeated and frequent sore throat, during a quiescent period should have tonsillectomy performed as a prophylactic measure.

6. A patient who harbors diphtheria organisms in his throat without clinical symptoms for a considerable period of time without response to local treatment, should have tonsils and adenoids ermoved.

CONTRA-INDICATIONS

1. Operation should never be undertaken during the acute stage of tonsilitis.

2. Diabetes is as much a contra-indication as it may be after any operation necessitating general anaesthesia.

3. Tonsillectomy is of no value during the acute stage of chorea, acute rheumatic fever, or endocarditis.

4. Size of tonsils alone without evidence of obstruction is not a reason for tonsillectomy.

5. Tuberculosis, unless indications are such as warrant the risk.

Trusting that the above answers your questions specifically, I remain,

Very truly yours,
F. D. Meader, M. D.,
Director Medical Service.

What conclusions can be drawn from the above accounts?

1. There is a growing condemnation in Detroit, as elsewhere, of the abuse of free and semi-free clinics by an underserving part of the public.

2. (a) The average wage earner with a dependent family of three children and upward does not earn sufficient income to provide against sickness and unlooked for contingencies.

(b) The average unskilled laborer with a family of three children cannot live independently in the city of Detroit, his average earning of about $100 to $120 per month being far from the $142 required for the minimum monthly budget.

(c) The industrial wage scale contributes to the pauperizing of the public.

(d) Of the attendants at free clinics many are wage earners with steady employment, or members of their family, who seek free medical service because their income is insufficient to support them. The only relief for this class could be either an increase in wage or a decrease in the cost of living.

3. The advisability of the charge of $2.00 for salvarsan administration by the Health Department is open to question.

4. The investigation of applicants for free treatment at the Department of Health venèreal clinic is not thorough enough.

The committee found nothing to merit adverse criticism of the Health Department in its methods of handling school children; also, its pre-natal work was approved.

The following resolution was adopted by your committee:

"Hospitals are urged to scrutinize carefully, by adequate social service, the financial status of the attendants at their outpatient department."

The committee wishes to remind our members that social service means assistance to the physician in the education of patients and the control of their environment. It is a medical function. Now, however, it is noted that in some quarters the physician is considered to be an adjunct of social service, and his movements are often directed by the social service worker. Perfect co-operation is necessary for the best results; however, the physician's interest must suffer unless he takes greater interest in community welfare. A passive interest is not enough. His fight against disease must be active and enthusiastic, and he will have less worries about his place in the community complex.

RECOMMENDATIONS AND ADVICE

1. Every member of this Society should realize that the march of progress upsets old customs and traditions, and that readjustments are more or less painful. New problems arise daily. The world changes, and the outlook of the profession of medicine must change with it. Complaisant inertia is dangerous to our profession, and the regular careful survey and study of economics in general and our economic position in particular are necessary to protect us from a postion of dependence and vallalage.

2. It is recommended that the restrictions now placed by the Department of Health about female delinquents affected with venereal disease be applied also to males who are similarly stationed and diseased, and that the city council or others in authority be urged to make such provisions.

3. It is recommended that any act on the part

of a physician to make capital out of the worries and fears of unfortunates afflicted with venereal disease and to use these as a lever for gouging shall be considered unethical.

4. Smallpox, diphtheria and typhoid prevention rests largely upon the private practitioner. Standard methods of immunization are in his hands, and he should constantly urge their use and employ them himself.

5. The local health regulations in the state should be as uniform as possible, and efforts by the State Department of Health to bring this about should have our approval.

6. The welfare of our profession demands that hospitals, dispensaries and clinics increase their efforts to weed out predatory patients, whether they may be seeking free or semi-free medical attendance.

7. Physicians doing clinical work are urged to refuse free or semi-free treatment when there appears good and sufficient reason to believe that a reasonable fee can be paid, and that the social service worker's report on any case be considered only on its merits.

8. It is recommended that complaint against employes of the Health Department first be laid before the executive staff of that department. If no satisfactory response is forthcoming that it then be submitted in detail to the Public Health Committee of this Society.

9. It is recommended that the appropriation for the conduct of the Department of Health include a sum sufficient to purchase arsphenamin for administration; indigent patients to receive arsphenamin free.

10. It is recommended that the Department of Health enlarge its social service work in the venereal disease clinic to the end that the recommendations in paragraphs 2 and 6 may be served.

11. It is advised that the methods of the Department of Health in the handling of school children and its pre-natal work are satisfactory, deserve our support, and should be continued.

12. On April 19, 1923, we were informed by the secretary of the Bricklayers' Union and also by the secretary of the Federation of Labor that the average income over the period of a year for the unskilled worker is either $3.60 or $3.00 per day, depending whether or not he is a union man. We are also informed that the minimum monthly budget for a family of father, mother and three children is about $147.00. This shocking disparity as a cause of dependence and poverty must be overcome. It is this disparity which is involved in the high sickness and death rates of infants, children and mothers. Therefore, it is recommended that this Society have a permanent committee on economics which will aim to assist in the solution of social and community problems in co-operation with the City Welfare Department, Board of Commerce, Federation of Labor, etc.

DETROIT HEALTH EXPOSITION

The Exposition movement as endorsed by this Society and as reported upon in past issues of the Bulletin is in process of development. To produce the best possible results the Public Health committee was considerably enlarged by the president, Dr. William Donald. A final report upon this project will be made at a later time.

MISCELLANEOUS ACTIVITIES

This committee commends the Michigan Chirododist Association, members of which legally practice Chirody in accordance with a Michigan state law, Act 64, Bill 45. Registered Chiropodists are thereby placed under the control of the board of registration in medicine.

Registered chiropodists are required by law to limit and to restrict their work to foot abnormalities seated above the true skin and are not permitted by their license to practice medicine or surgery.

The committee has recommended to the council that members of this Association be recommended for positions in the various orthopedic clinics, their work to be directed by orthopedic surgeons; accepted and passed by the council.

The attempt to keep hospital, clinical, and conference schedules posted on our bulletin board has not met with the support it deserved; however, this service is rendered in part by the Bulletin of our Society.

Respectfully submitted,

R. A. C. Wollenberg,
Chairman.

May 14, 1923.

Full and final details in connection with the Michigan Health Exposition will not be at hand for several weeks. A complete report on this undertaking will be presented to the Society early in the fall of this year.

The committee takes this opportunity to extend its most hearty thanks and grateful acknowledgment to the members of the Wayne County Medical Society, the Detroit District Dental Society, the Detroit Retail Druggists' Association, the First District of Michigan State Nurses Association, the hospitals, the Detroit City and Michigan State Departments, the Federation of Women's Clubs, the Detroit Community Fund, the many civic and community organizations, the merchants and manufacturers, the men, women and children who contributed to our program, and especially to the representatives of the National Health Exposition Association who, by their whole-hearted efforts and support, brought the exposition to a successful end, and who have added a chapter to the health program of our beloved city.

Respectfully submitted,

R. A. C. Wollenberg,
Chairman.

ADDITIONAL REPORT

Agreeable to Dr. Chester A. Doty of this committee and to the executives of the Department of Health, a committee was appointed by your chairman to further investigate a number of cases which were being treated in the Board of Health venereal disease clinic which made full treatment questionable.

It was the desire of your chairman to bring our Society and the Department of Health into complete agreement in the conduct of this clinic, and the report of the committee consisting of Dr. Arthur E. Schiller and Dr. Wm. E. Keane is the result of most painstaking work . Their report follows:

Detroit, Mich., June 15, 1923.

In accordance with the request of the chairman of the Public Health committee we have investigated several cases selected at random from a list of 75 which appeared to Dr. C. A. Doty of the Wayne County Medical Society as being patients financially competent to be under the care of private physicians.

We find and believe that the great majority of these cases, considered from the standpoint of public health, primarily are best handled by the venereal department of the Board of Health.

It is our belief that while many of these patients are listed as earning a fair wage, they are mostly of the "floating," irresponsible type and are no good either financially or morally in keeping their obligations to the private physician.

We recommend, however, strict investigation of these patients as to their economic situation as it is quite possible for patients to falsify answers when first seen at the clinic and thus receive an O. K. for treatment to which they are not entitled.

William E. Keane,
Arthur E. Schiller.